"A STUDY TO ASSESS THE EFFECTIVENESS OF PSYCHO EDUCATION MODULE ON KNOWLEDGE REGARDING DEMENTIA AMONG CARE GIVERS OF OLD AGE PEOPLE RESIDING IN SELECTED COMMUNITY AREA"

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CERTIFICATE

This is to certify that this dissertation titled, **"A STUDY TO ASSESS THE EFFECTIVENESS OF PSYCHO EDUCATION MODULE ON KNOWLEDGE REGARDING DEMENTIA AMONG CARE GIVERS OF OLD AGE PEOPLE RESIDING IN SELECTED COMMUNITY AREA"** Is a bonafide work done by **Mrs.R.Myvizhi,** College of Nursing, Madras Medical College, Chennai-03 submitted to **The Tamil Nadu Dr.M.G.R Medical University, Chennai** in partial fulfillment of the university rules and regulations towards the award of the degree of **Master of Science in Nursing, Branch - V, Mental Health Nursing,** under our guidance and supervision during the academic period from 2013-2015.

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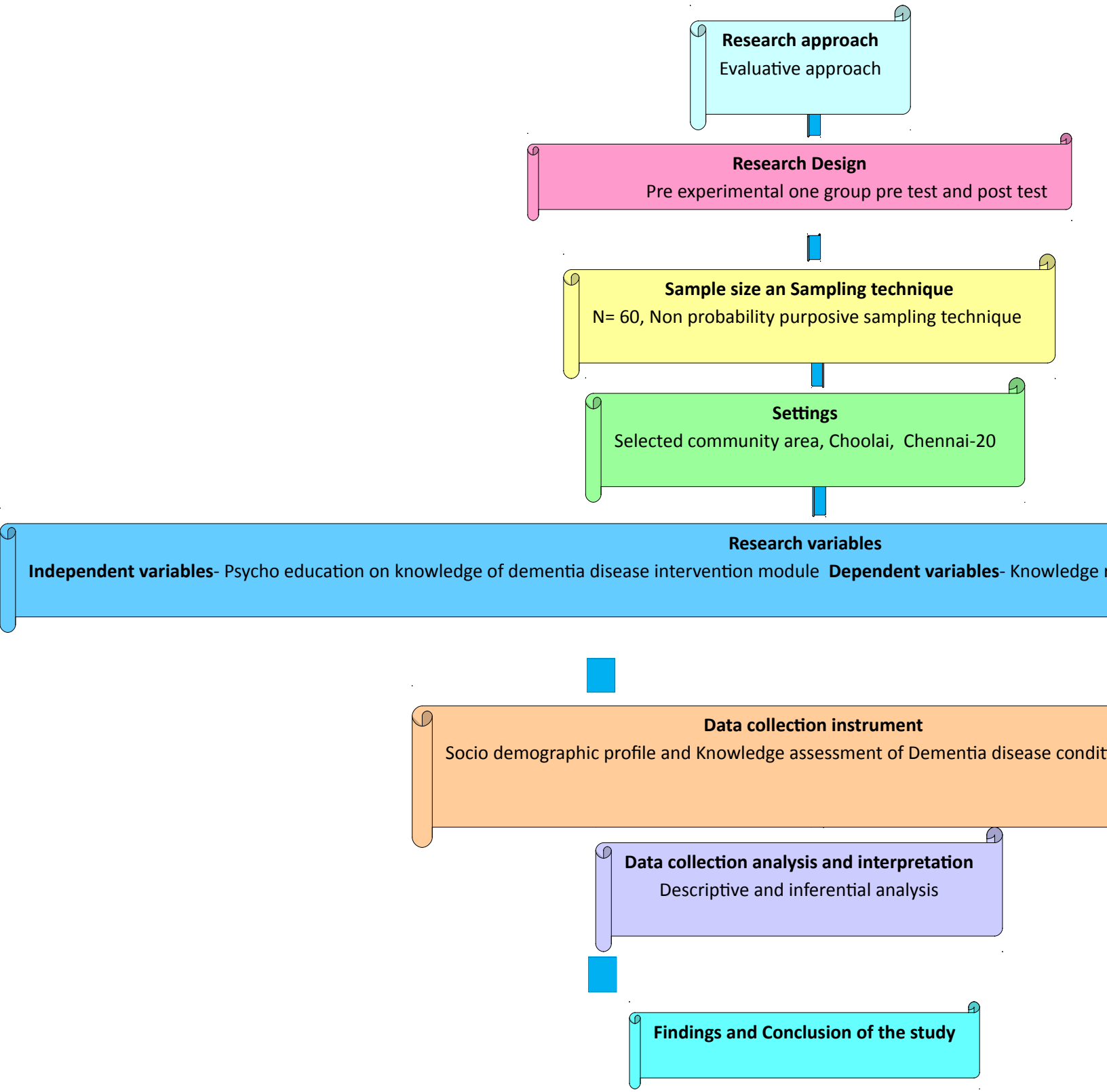
ABSTRACT

Patients with chronic illnesses have intricate treatment protocols that require caregiver involvement, further complicating this already difficult care. Many family caregivers report they don't have the necessary skills and knowledge to provide sustained care for a person with a dementia this was a study to assess the effectiveness of psycho education module on knowledge regarding dementia among care givers of old age people residing in selected community area. The conceptual frame work adopted for this study was modified Wiedenbach model. The research approach used for this study is Interventional approach, and research design was one group pre test and post test design. The size of the sample study was 60. In this study 40.0% of the caregivers are having inadequate knowledge, 53.3% of them are having moderate knowledge and 6.7% of them are having adequate knowledge. After the administration of psycho education, none of the caregivers are having inadequate knowledge, 15% of them are having moderate and 85%of them are having adequate knowledge. Considering overall, in pretest, caregivers scored 55.0 and after psycho education, they are able to score 87.40 score. So the difference is 32.4.By comparing the effectiveness of psycho education, This is the net benefit of this study. Effectiveness of study was analysed using proportion with 95%. The association between level of knowledge gain of care givers of dementia clients were and their selective demographic variables. Younger **χ2=5.07 p=0.02***, more educated **χ2=6.00p=0.04***joint family **χ2=6.66p=0.01****and less year caregivers **χ2=6.78 p=0.01**** gained more knowledge.

ABSTRACT

Patients with chronic illnesses have intricate treatment protocols that require caregiver involvement, further complicating this already difficult care. Many family caregivers report they don't have the necessary skills and knowledge to provide sustained care for a person with a dementia this was a study to assess the effectiveness of psycho education module on knowledge regarding dementia among care givers of old age people residing in selected community area. The conceptual frame work adopted for this study was modified Wiedenbach model. The research approach used for this study is Interventional approach, and research design was one group pre test and post test design. The size of the sample study was 60. In this study 40.0% of the caregivers are having inadequate knowledge, 53.3% of them are having moderate knowledge and 6.7% of them are having adequate knowledge. After the administration of psycho education, none of the caregivers are having inadequate knowledge, 15% of them are having moderate and 85%of them are having adequate knowledge. Considering overall, in pretest, caregivers scored 55.0 and after psycho education, they are able to score 87.40 score. So the difference is 32.4.By comparing the effectiveness of psycho education, This is the net benefit of this study. Effectiveness of study was analysed using proportion with 95%. The association between level of knowledge gain of care givers of dementia clients were and their selective demographic variables. Younger **χ2=5.07 p=0.02***, more educated **χ2=6.00p=0.04***joint family **χ2=6.66p=0.01****and less year caregivers **χ2=6.78 p=0.01**** gained more knowledge.



SCHEMATIC REPRESENTATION OF THE STUDY

BIBLIOGRAPHY

Books

1. **Ahuja Niraj (2002),** A short text book of Psychiatry, Fifth edition, New Delhi, Jaypee publishers, PP.No.37-47

2. **Burns Nancy Grove K.Susan (1999**), Understanding Nursing Research, Second edition, New Delhi, Harcourt Publishers

3. **Carlton, K.E. (2007)** The Science of Addiction, W.W.Norton and Company

4. **David J (1998**), Dementia and Treatment, Second edition, New York, John Wiley, PP.No.47-49

5. **Encyclopedia of drugs, (2001)** Dementia and drug treatment, Second edition USA, Macmillan reference, PP.No.356-359

6. **Fortinash M.Katherine, Holoday A. Patricia (1996**), Psychiatric Mental Health Nursing, First edition, Missouri, Mosby PP.No. 350-353

7. **Frisch, N.C., & Frisch, L.E. (2002**) Impact of dementia on families, Psychiatric Mental Health Nursing, New York

8. **Gupta S.P.(1998)**, Stastical Methods, 28th edition, New Delhi, Sultan Chand and sons publishers

9. **James.A.Fain (2003**), Reading Understanding and Applying Nursing Research, 2nd edition, F.A.Davis Company, PP.No.46-88

10. **Joan Welkowitz (2000**), An Introductory Statistics for Behavioral Sciences, 4th edition, Tokyo, Harcourt Brace College Publication, PP.No.50-80

11. **Kothari, C.R. (2001**), Research Methodology, Methods and Techniques, 2nd edition, New Delhi, VishwaPrakash Publications, PP.No.39-67

12. **Mahajan.B.K. (1998**), Methods in Biostatistics for medical students and research workers, 2nd edition, New Delhi, Jaypee Brothers Publications PP.No.146-151

13. **Mahal A., (2000**) What works in care of elderly? Evidence from rural India, Economic and Political weekly. P.54-57

14. **Malhotra A, Mohan A., (2000**) National policies to meet the challenge of care of dementia clients: Programmes and implementation. Indian J Psychiatry P.42-57

15. **Mary.C.Townsend (2007**), Psychiatric Mental Health Nursing, First Indian EDitio, New Delhi, Jaypee Publishers, PP.No.412-418

16. **Mohr K.Wanda (2006),** Psychiatric Mental Health Nursing, sixth edition, Philadelphia, Lippincott Williams and Wilkins, PP.No.688-694

17. **Parker M.E (2001)** Nursing theories and nursing practice, 4th edition, Philadelphia, F.A.Davis company, PP.No.45-64

18. **Peter. M, Ronald, M (2002**) Treating Dementia:A coping skills training guide, New York;Guilford Publishers

19. **Polit F.Denise, Hungler P.Bernadette (2004**) Nursing research, seventh edition, Philadelphia, Lippincot Williams and Wilkins

20. **Rao Sunder, Richard (2003**) An Introduction to biostatistics, Third edition, New Delhi, Prentice-hall India Private Limited

21. **Sadock J.Benjamin and Sadock A.Virginia (2005**) Kaplan and Sadock's Comprehensive Textbook of Psychiatry, Vol.I edition, Philadelphia, Lippincott, Williams and Wilkins, PP.No.1170-1191

22. **Scott T.Walters, John S.Baer (2002**) Talking with elderly with dementia, Motivational strategies for reducing elderly abuse, London: The gulf ford press

23. **Stuart W Gail, Laria T.Michele (2005)**, Principles and Practice of Psychiatric Nursing, eighth edition, New Delhi:Elsevier, PP.No.502-507

Journal

1) Australian Institute of Health and Welfare: Dementia in Australia. Cat. no. AGE
70. Canberra: AIHW; 2012.
2) Barrett J, Haley W, Harrell L, Powers R: Knowledge about Alzheimer's disease among primary care physicians, psychologists, nurses, and social workers. Alzheimer Dis Assoc Disord 2007, 11(2):99–106.
3) Dillman D: Mail and other self-administered questionnaires. In Handbook of Survey Research. New York: Academic Press; 1983.
4) Perry M, Drasković I, van Achterberg T, Borm G, van Eijken M, Lucassen P,Vernooij-Dassen M, Olde Rikkert M: Can an EASY care based dementia training programme improve diagnostic assessment and management of dementia by general practitioners and primary care nurses? The design of a randomised controlled trial. BMC Health Serv Res 2008, 8:71.Sullivan K, O'Conor F: Providing education about Alzheimer's disease Aging Mental Health 2001, 5(1):5–13.
5) Borbasi S, Jones J, Lockwood C, Emden C: Health professionals' perspectives of providing care to people with dementia in the acute setting: Toward better practice. Geriatr Nurs 2006, 27(5):300–308.

6) Millard F, Kennedy L, Baune B: Dementia: opportunities for risk reduction and early detection in general practice. Aust J Prim Health 2011, 17:89–94.
7) Spector A, Orrell M, Schepers A, Shanahan N: A systematic review of 'knowledge of dementia' outcome measures. Ageing Res Rev 2012, 11(1):67–77.
8) Low L, Anstey K: Dementia literacy: Recognition and beliefs on dementia of the Australian public. Alzheimers and Dementia 2009, 5:43–49.
9) Jackson E, Cherry K, Smithman E, Hawley K: Knowledge of memory aging and Alzheimer's disease in college students and mental health professionals. Aging Ment Health 2008, 12(2):258–266.
10) Millard F, Baune B: Dementia - who cares? A comparison of community needs and primary care services. Aust Fam Physician 2009, 38(8):642–649.
11) Bailey K: Student awareness of Alzheimer's disease. Am J Alzheimers DisOther Demen 2000, 15(6):375–378.
12) Peterson D, Berg-Weger M, McGillick J, Schwartz L: Basic care 1: The effect of dementia-specific training on certified nursing assistants and other staff. Am J Alzheimers Dis Other Demen 2002, 17(3):154–164.
13) Foreman P, Gardner I: Evaluation of education and training of staff in dementia care and management in acute settings. In Edited by Services ACBDoH. Melbourne, Victoria: Aged Care Branch; 2005.
14) Eriksson C, Saveman B-I: Nurses' experiences of abusive/non-abusive caring for demented patients in acute care settings. Scand J Caring Sci 2002, 16(1):79–85.
15) Tolson D, Smith M, Knight P: An investigation of the components of best nursing practice in the care of acutely ill hospitalized older patients with coincidental dementia: A multi-method design. J Adv Nurs 1999,30(5):1127–1136.
16) Moyle W, Borbasi S, Wallis M, Olorenshaw R: Acute care management of older people with dementia: A qualitative perspective. J Clin Nurs 2011, 20(3–4):420–428.
17) Dieckmann L, Zarit S, Zarit J, Gatz M: The Alzheimer's Disease Knowledge Test. Gerontologist 1988, 28(3):402–407.

18) Carpenter B, Balsis S, Otilingam P, Hanson P, Gatz M: The Alzheimer's Disease Knowledge Scale: Development and psychometric properties.Gerontologist 2009, 49(2):236–247.
19) Carpenter B, Zoller S, Balsis S, Otilingam P, Gatz M: Demographic and contextual factors related to knowledge about Alzheimer's disease. AmJ Alzheimers Dis Other Demen 2011, 26(2):121–126.
20) Nordhus I, Sivertsen B, Pallesen S: Knowledge about Alzheimer's Disease among Norwegian psychologists: The Alzheimer's disease Knowledge Scale. Aging Ment Health 2012, 16(4):521–528.
21) Hudson J, Pollux P, Mistry B, Hobson S: Beliefs about Alzheimer's disease in Britain. Aging Ment Health 2012, 16(7):828–835.
22) Sullivan K, Muscat T, Mulgrew K: Knowledge of Alzheimer's disease amongst patients, carers, and non-carer adults: misconceptions, knowledge gaps, and correct beliefs. Top Geriatr Rehabil 2007, 23(2):148–159.
23) Practical considerations in raking survey data. http://surveypractice.wordpress. com/2009/06/29/raking-survey-data/.
24) Rashmi gupta, Vijayan kumara pillai ,Eileen f. levy (2012).Relationship quality and elder caregiver burden in India, journal of social intervention: theory and practice – 2012 – volume 21, issue 2
25) Queensland Health and Client Support and Workforce Informatics Finance Solutions Finance Branch: Townsville Health Service District Quarterly Workforce Performance Measures Report. Brisbane, Australia: Queensland Health; 2009:1–32.
26) Titler MG, Herr K, Schilling ML, Marsh JL, Xie X, Ardery G, Clarke WR, Everett LQ:Acute pain treatment for older adults hospitalized with hip fracture:Current nursing practices and perceived barriers. Appl Nurs Res 2003,16(4):211–227.
27) Wendy Smyth, Elaine Fielding, Elizabeth Beattie, Anne Gardner,(2013) A survey-based study of knowledge of Alzheimer’s disease among health care staff, Smyth et al. BMC Geriatrics 2013, 13:2

Net resources:

- www..wikipedia.org/wiki/dementia
- http://www.eurojournals.com/ejsr.htm
- http://www.ciap.health.nsw.gov.au/hospolic/strincents/htm
- http://www.demential.in/treatment/html
- http://www.pubmed.gov/
- www.indiandementia.org/
- www.hopetrustindia.com/
- www.lonolulu.hawaii.edu
- www.tanijournal.htm
- www.ncbi.hlm.nih.gov/pubmed

CHAPTER –I

INTRODUCTION

“If the head and body are to be well, you need to begin by curing the soul”

- Plato

Worldwide, there is an increase in the number of ageing population. By the year 2050, the global population of 65 years and above is expected to increase to 86billion in 2050 **(Hebert, Scherr, Bienias, Bennett, & Evans, 2012).** Increase in life expectancy and development of medical research during the twenty first century has produced an aged population of an unprecedented size and longevity. Ageing leads to several biological and psychological changes that take place over time and results in progressive loss of functional capacity.

The aged have to cope up with many physical and mental health problems with advancing age requiring constant attention and medical care. Depressions, Hypertension, Diabetes, Arthritis, Dementia, and Alzheimer’s are highly prevalent among the aged. Patients with chronic illnesses and multiple co morbid conditions have intricate treatment protocols that require caregiver involvement, further complicating this already difficult care. Because better available treatments have extended the life spans of most patients with chronic illnesses, caregiver involvement and their co-operation and participation often is required for several years **(Barbara given 2013).**

Dementia is the word derived from the Latin word de – “apart, away” and “men’s” – mind. Dementia is a progressive brain dysfunction which result in a restriction of daily activities and in most cases leads in the long term to the need for care. Dementia is a degenerative, irreversible, and progressive brain disorder. It is widely assumed that old aged persons with dementia are stigmatized and that its magnitude is comparable to or greater than other populations of persons with chronic illness **(Burgener & Berger, 2010).**

One of the common conditions associated with ageing is dementia. It is defined as a progressive and largely irreversible clinical syndrome that is

characterized by a widespread impairment of mental function**.(Zurraini Arabi 2013)** Dementia is a non-specific illness syndrome in which affected areas of cognition may be memory, attention, language, and problem solving, cognitive dysfunction that has been seen only over shorter times, in particular less than weeks must be termed delirium. The symptoms of dementia can be classified as either reversible or irreversible depending upon the etiology of the disease. Less than (10%) of cases of dementia are due to causes that may presently be reversed with treatment.

Dementia is the most feared and degenerating disorder of late life. Current estimates reveals that there are about 18 million cases of dementia in the world and by 2025, there will be about 34 million suffering from dementia. The overall prevalence of dementia ranges from 5 % to 7 %. Alzheimer's disease is the most common dementing disorder accounting for 80 % of all cases of dementia.

The causes of dementia depend on the age at which symptoms begin. In the elderly population (usually over 65 years of age), a large majority of cases of dementia are caused by Alzheimer's disease, Vascular dementia or both. The Hypothyroidism sometimes causes slowly progressive cognitive impairment as the main symptom, and this may be fully reversible with treatment. The Fronto-temporal lobar degeneration and Huntington's disease account for most of the remaining other cases.

Dementia is not merely a problem of memory. It also reduces the ability to learn reason, retain or recall past experience and there is also loss of patterns of thoughts, feelings and activities. Additional mental and behavioral problems often affect people who have dementia, and may influence quality of life and the need for institutionalization. As dementia worsens individuals may neglect themselves and may become disinhibited, the individual may become incontinent as their condition worsens. Depression affects (20–30%) of people who have dementia, and about (20%) have anxiety. Psychosis and agitation/aggression also often accompany dementia.

As the disease stage progresses to the middle stage, patients might still be able to perform tasks independently, but may need assistance with more complicated activities. In the late stage patient will not be able to perform even the simple tasks independently and will require constant supervision. They may eventually to lose the ability to swallow food and fluid and this can ultimately lead to death.

There is currently no cure for the disease. Currently available medications offer relatively small symptomatic benefit for some patient but do not show disease progression. It helps a little for the memory.

The sun will continue to show its rays on the world. The waves of the vast ocean will continue their rush to reach the shore and the wind will continue to blow the leaves of the tree.

Now we have to accept the patient with Dementia and give them a better hopeful tomorrow. Family caregivers of people with dementia, often called the invisible second patients, are critical to the quality of life of the care recipients. The majority of people with dementia live in the community vary between 70% to 81%, 3-6 and for approximately 75% of these individuals, care is provided by family and friends. The largest proportion of those caregivers of dementia clients were spouses, followed by children and children in-law, mostly female.

1.1. NEED FOR STUDY:

Morbidity and Mortality associated with Dementia Global Morbidity and Mortality

- In 2000, age-standardized dementia mortality rate was 6.7 and 7.7 for 100,000 male and female respectively.
- 24.3 million have dementia
- 4.6 million new cases per year

- Worldwide dementia contributes 4.1% of all disability-adjusted life years (DALYs) and 11.3% of years lived with disability and 0.9% of years of life lost6.

India Morbidity and Mortality

- Age standardized death rate of 12.1 per 100,000 people
- 1.8 million People have dementia in India and South Asia in people >60 years of age.
- 400,000 new cases per year for India + South Asia.
- 1,034 per 100,000 DALYs.

Patients with chronic illnesses have intricate treatment protocols that require caregiver involvement, further complicating this already difficult care. Many family caregivers report they don't have the necessary skills and knowledge to provide sustained care for a person with a dementia, so they lack confidence and feel unprepared. The demands of providing care depend on factors such as the patient's personality; the type or stage of illness; and the caregivers' physical, cognitive, social, organizational, and psychological knowledge and skills. Professionals must assess care demands while evaluating the caregiver's availability, capacity, knowledge, skills, competing family roles, and resources. **(Barbara Given, Paula, Sherwood 2008)**

There are an estimated 30 million people with dementia worldwide currently, and this figure is likely to double every 20 years. The majority of people with dementia live in the community estimates vary between 70% to 81%, 3-6 clients and for approximately 75% of these individuals, care is provided by family and friends. In India there are 3.7 million Indians with dementia and the total societal costs is about 14,700 crore. While the numbers are expected to double by 2030, costs would increase three times roughly 43 crores. Families are the main carers and they need support. **(The Dementia India Report2010)**

The challenge posed by dementia as a health and social issue is of a scale we can no longer ignore. Despite the magnitude, there is gross ignorance, neglect

and scarce services for people with dementia and their families. We know that dementia is not part of aging and is caused by a variety of diseases. We now have a range of options to treat the symptoms of dementia and offer practical help to those affected **(Henry Brodaty 2009)**

The sufficiency of caregivers' knowledge and skills vary depending on patient acuity, illness type, or both. We and colleagues suggest that practitioners should evaluate care demands, caregiver knowledge and capacity, caregiver skills, family roles, and available resources. In which therapeutic communication reduces stress. Self care motivation will prevent frustration. Caregivers also need to learn to monitor patients for new signs and symptoms, adverse events, and positive responses to treatment.

Most studies don't organize or classify interventions according to caregivers' tasks or the knowledge and skills they require, but this information is vital for planning and implementing interventions that will help them. The concepts of mastery, preparedness, and competence have been considered as necessary components for effective decision making and problem solving by family caregivers, but the formal care system has paid little attention to these components.

Recently investigators have suggested that family caregivers require both knowledge and skill to provide care and to reduce their own distress. Nurses should assess the care situation and help family caregivers develop the skills they need. Caregivers who have these skills report lower levels of burden, stress, and distress. These should cover the types of knowledge and skills family caregivers need the conditions under which information and skills.

Psycho educational interventions that required active participation and involvement by caregivers had the broadest effects, and provide emotional and educational support to caregivers. Interventions that increase knowledge and skills are targeted at caregivers who work with patients with dementia more often than at those who deal with other illnesses.

After the intervention, caregivers became informed and confident about giving care and weren't more burdened when patient care demands increased.

Other studies document that problem-solving programs help caregivers feel informed about community resources. Caregivers were more positive after home visits and Psycho educational interventions by nurses.

1.2 STATEMENT OF PROBLEM:

A study to assess the effectiveness of psycho education module on knowledge regarding dementia among care givers of old age people residing in selected community area.

1.3 OBJECTIVES:

1. To identify the socio demographic variables of the care givers.
2. To assess the knowledge regarding dementia before psycho education intervention.
3. To assess the knowledge regarding dementia after psycho education intervention.
4. To evaluate the effectiveness of the psycho education intervention.
5. To associate the level of knowledge with selected demographic variables.

1.4. OPERATIONAL DEFINITIONS

- **ASSESS**
  Assessment refers to the process of documents the knowledge on dementia among caregivers of old age people.
- **EFFECTIVENESS**
  It refers to the outcome of the psycho education module.
- **KNOWLEDGE**
  It refers to caregivers of old age people awareness regarding dementia as measured by scores obtained according to the response to the items on the structured questionnaire.
- **PSYCHOEDUCATION**
  It is a planned education module given to educate the clients with dementia about symptoms effects and management to caregivers of old age people.

- **OLDAGE PEOPLE**
  In these study caregivers of old age refers to both males and females with in the age group of 60 to 80 years.

- **DEMENTIA**
  Global impairment of cognitive functioning that is progressive and interferes with social and occupational abilities.

1.5 ASSUMPTIONS

The investigator assumes that

- Caregivers of old age people will have some knowledge about dementia.
- caregivers of old age people will improve knowledge about dementia via psycho-education module.

1.6 HYPOTHESIS:

H_1: There will be statistically significant difference between pre- test and post -test knowledge scores of the care givers of old age people with dementia undergoing psycho-education intervention.

H_2: There will be statistically significant association between the knowledge scores care givers of old age people with dementia undergoing psycho- education intervention.

1.7 DELIMITATION:

- The study limited for old age people above the age of 65 years only
- Study was limited for 4 weeks only
- Study was conducted within community area only.

CHAPTER -II
REVIEW OF LITERATURE

The review literature involves identification and analysis of relevant publications that contain information pertaining to the research problem

- James A. Fair

This chapter presents similar research studies which have been conducted earlier by researchers. This chapter contains both Indian and International studies

related to Dementia, family care givers, psycho educational module, and care giver burden.

The literature found relevant to the study has been presented under the following headings.

- 2.1 Studies related to knowledge of dementia among the care givers of old age.
- 2.2 Studies related to problems and burden for caring dementia clients and old age people.
- 2.3 Studies related to other interventions for family care givers among dementia clients.

2.1 STUDIES RELATED TO KNOWLEDGE OF DEMENTIA AMONG THE CARE GIVERS OF OLD AGE

Krystyna Klodnica Kouri, Francine C. Duchrame, Francine Gioroux (2014) conducted psycho educational intervention study among the care givers of family members tested on five proximal outcome variables: caregiver knowledge, perceptions of communication difficulties and degree of perceived disturbance related to these difficulties, self-efficacy and skills. Guided by a theoretical framework that encompassed geragogy, the McGill model of nursing and self-efficacy theory, the intervention was evaluated via an experimental design with pre-post tests. 50 family caregivers were randomly assigned to an experimental group (intervention program), or to a control group (information flier on communication and memory). Statistically significant effects were found on four dependent variables: caregiver knowledge78%, degree of disturbance related to communication difficulties 82%, self-efficacy 91% and skills 93%. No significant effects were observed in regard to the perceived presence of communication difficulties. This communication program serves as a useful tool to prepare caregivers for their new role.

Camila Manuela Marim; Valter Silva; Monica Taminato; Dulce Aparecida Barbosa (2013) analyzed the effectiveness of educational and support programs for caregivers on reducing their burden. The method used was a systematic review. 7 randomized clinical studies were included. These studies compared an educational program with standard care delivery, assessing the burden of caregivers through the Zarit Burden Interview. After the analysis of sensitivity, 4 studies were grouped in the meta-analysis showing a statistically significant reduction in caregiver burden among the participants of educational and support programs.

Naveena B.M.(2012) evaluated the knowledge of home based care among care givers of persons with dementia in Bangalore. Data collected from the 60 samples by the investigator made questionnaire. The study reveals that overall mean score obtained by the subjects was 18.80 (47%) with standard deviation 7.481 in the pre test and the overall knowledge obtained score was 30.85 (77.12) with standard deviation 7.427 in the post test. The obtained‘t’ value 11.156 was greater than the table value at the degree of freedom 39 was found to be significant at the level of 0.001.

Sarah Mariano Llanque (**2012)** examined the impact of a psycho educational intervention, the Family Series Workshop, on levels of coping, care giving competence, and stress among caregivers (N = 35) of community-dwelling individuals with dementia. The Stress Process Model served as the conceptual framework. A non-controlled, pretest-posttest research design was employed. Caregivers were recruited for this study from three sites in a Midwestern metropolitan area: two churches and a hospital. Data were collected with paper/pencil questionnaires at baseline (Time 1) and post-intervention (Time 2). Using paired t-tests with random effect, caregiving competence significantly increased (p = 0.036) from Time 1 (M = 11.6 points) to Time 2 (M = 14.6 points). Although, caregiver’s coping and stress did not change significantly, scores improved for coping from Time 1 (M = 58.6 points) to Time 2 (M = 72.6 points)

and stress from Time 1 (M = 20.7 points) to Time 2 (M = 21.2 points). Regression analysis was also used to examine the relationship between coping, caregiving competence, and stress. A significant association was found concerning the mediator coping and its association with caregiving competence ($p < 0.001$) and stress ($p = 0.008$). Caregiver competence was significantly correlated with stress ($p = 0.046$).

Carpenter BD, Zoller SM, Balsis S, Otilingam PG, Gatz M.(2011) conducted on accurate knowledge about dementia disease is essential to address the public health impact of dementia. This study examined dementia knowledge in 794 people who completed the Dementia Knowledge Scale and questions about their background and experience with dementia. Whereas overall knowledge55% was fair, there was significant variability across groups. Knowledge was highest among professionals working in the dementia field, lower for dementia caregivers and older adults, and lowest for senior center staff and undergraduate students. Across groups, respondents knew the most about assessment, treatment, and management of dementia were 78% and knew the least about risk factors and prevention were 88%.

Henry Brodaty, Kate Roberts, Karin Peters (2011) conducted psycho educational interventions among the Dementia caregivers are known to be distressed. We investigated the effectiveness of one model of intervention comprising a structured package of 6 sessions of training, focusing on education, stress management and problem behaviour management in a group setting. 3 groups of caregivers were compared-those who had completed (N= 33) or partially completed (N= 22) training and a control group (N= 26)-on measures of psychological stress 47%, burden 57%, satisfaction with life 65%, well-being 76% and knowledge 92%. There were no significant differences in outcome between the three groups. We conclude that, with methodological qualifications, this quasi-experimental study of one model of training was not empirically

effective. Interventions for caregivers should be tailored to individual needs from a range of techniques encompassing psychological and practical strategies.

Mariella GuerraI, Cleusa P. Ferri, Magaly FonsecaII,Sube BanerjeeIII,Martin Prince (2011) tested the effectiveness of the caregiver intervention among people with dementia and their caregivers in Lima, Peru. A randomized controlled trial was performed involving 58 caregivers of people with dementia that received the intervention in the beginning of the trial (n = 29) or six months later (n = 29). The intervention consisted of three modules: 1) assessment (one session); 2) basic education about dementia (two sessions); and 3) training regarding specific problem behaviors (two sessions). Main outcome measures: Caregivers and patients with dementia were assessed at baseline and after six months. For caregivers, the measures included strain (Zarit Burden Interview), psychological distress (SRQ-20), and quality of life (WHOQOL-BREF). Dementia patients completed scales assessing behavioral and psychological symptoms (NPI-Q) and quality of life (DEMQOL). It reveals that caregivers in the intervention group reported significantly decreased strain measures six months after the intervention compared to controls. No group differences were found in respect to the caregivers' psychological distress and to quality of life in both caregivers and patients.

Mary Sauceda (2011) conducted study family psycho education for latino population with dementia living in US. Several forms of interventions for dementia caregivers have been suggested, such as practical assistance (e.g. respite), education, emotional support provision, and multi-component interventions that are different from usual treatment (information about resources and advice upon request, but they did not have formal counselling sessions for and their family members did not have contact with the counsellors). Although users report high levels of satisfaction (82%) with these services, narrative reviews on objective outcome measures, such as caregiver's burden (43%) is

declined and psychological health (90%) or institutionalization of people with dementia, have been inconclusive.

Timothy Kwok, Ko-Chuen Lam, Florence Ho (2011) evaluated the knowledge of dementia among health and social care undergraduates in Hong Kong. The association between such knowledge and the undergraduates' self-efficacy in dementia care giving was also studied. Dementia knowledge was assessed by a modified version of the Alzheimer's Disease Knowledge Test (ADK). The General Self-Efficacy Scale (GSE) was amended to also measure dementia-caregiving self-efficacy (DSE). Two hundred and forty-two final year undergraduates from four different health and social care disciplines participated in the study. The overall ADK score was 7.4 (SD = 3.7) out of 20, indicating a generally poor knowledge of dementia. DSE and hours of dementia education were positively correlated with knowledge of dementia.

Barbara Hicks, Barbara Kopp Miller, (2009) conducted involving the effects that knowledge of dementia disease has on caregivers as well as the possible consequences of this knowledge. The major purpose of the current study was to determine the amount of knowledge caregivers possessed. The second purpose was to explore possible correlates of knowledge of dementia. 100 and one caregivers participated in the study. Participants were given a 30 item test which consisted of 15 multiple choice items and 15 true/false items. The caregivers answered an average of 46 %of the items correctly. Female caregivers answered more questions correctly 80% compared to male caregivers were about 67%. It shows that education about dementia disease is needed, especially in caregivers of patients diagnosed with possible or probable dementia. Strategies and suggestions for dissemination of this information are presented.

Proctor R. Martin, Hewison .J (2009) investigates on family care givers existing knowledge about dementia, their coping style and psychological morbidity. 50 family care givers and patients attending day services were recruited. Family care

givers were given questionnaires to assess knowledge of dementia, preferred coping style, anxiety, depression and strain. The results indicated that family care givers who demonstrated more knowledge about the biomedical aspects of dementia were more anxious ($p < 0.05$). Furthermore, family care givers who had a preferred coping style of monitoring for threat relevant information were more anxious ($p < 0.005$). it revealed and concluded that Understanding more about those factors that are associated with knowledge about dementia will help to identify profiles of family care givers who are in need of education and in matching individually tailored interventions to family care givers with specific learning needs.

CKY Lai1 **JCC Chung**, **(2009)** examined the perceived knowledge level of dementia caregivers and the related support services available to them by recruited 144 respondents from three non-governmental organisations, and collected data using a structured questionnaire distributed in person and via postal mail. More than half of all family caregivers knew about dementia, but their knowledge about corresponding aspects of care or available support services was not extensive. We found informational pamphlets and the media to be useful means of disseminating information. In general, family caregivers expressed the need to learn how to care for their relative suffering from dementia. The respondents revealed a lack of knowledge (65%) about services available in the community, which could be one of the reasons for their low levels of utilisation, by that psycho educational intervention reveals that 90% of knowledge gain.

2.2 STUDIES RELATED TO PROBLEMS AND BURDEN FOR CARING DEMENTIA CLIENTS AND OLD AGE PEOPLE.

Arunima Gupta, rajnee Sharma (2013) conducted study to assess and compare the burden and coping styles of care givers of dementia patients from Haryana. A cross sectional study consisted of 75 care givers (44 male 31 female) of

psychiatric clients with the age range of both group was between 26-65 years. Family burden interview schedule consists of 24 items grouped under 6 areas viz: Financial burden, Disruption of family activities, Disruption of family leisure, Disruption of family interaction, Effect of physical health of others, Effect of mental health of others, 0-2 scale; i.e. '0' means burden, '1' means moderate burden and '2' means extreme burden and the total score ranges from 0 to 48, reliability and validity were found to be 0.87 and 0.72 respectively. It reveals that Financial burden (8.29), Disruption of family activities(10.35), Disruption of family leisure(6.60), Disruption of family interaction (3.45), Effect of physical health of others(1.97), Effect of mental health of others (2.63), Total burden was (33.49).

Janine Diehl-Schmid, Eva-Maria Schmidt, Sabine Nunnemann, Lina Riedl, Alexander Kurz, Hans Förstl, (2013) conducted that burden among caregivers of patients with frontotemporal dementia (FTD) is high. However, little is known about the specific problems, the factors that contribute to caregiver burden and the needs of the FTD caregivers— particularly those needs that are accessible by external support strategies. Data collected by developed a standardized questionnaire that addressed burdens, problems, and the actual needs of FTD caregivers. A total of 94 caregivers were interviewed. It appears that changes in the patients' behavior and in the interpersonal relations between caregivers and patients are associated with caregiver depression. The most important needs and requests of the caregivers included information and psychosocial support through educated staff, financial support as well as the education of medical staff about the disease.

Raquel L. Santos; Maria F. B. de Sousa; Ana C. Ganem; Thais V. Silva; Marcia C. N. Dourado (2013) explored differences in disease awareness in participants of a psycho educational group designed for Latin American caregivers of people with dementia. The participants of a group developed at an outpatient unit for Alzheimer's disease. Interpretative phenomenological analysis

was used to analyze differences in the caregivers' reports. It reveals that the participants, mostly spouses and daughters, presented moderate caregiver burden and different levels of awareness (aware, partially aware, or unaware). Disease awareness and the development of coping strategies were influenced by familism, religiosity, and duty. Becoming a caregiver was considered positive in some cases, due to religious convictions and beliefs related to the importance of care giving. Caregiver unawareness may reflect an attempt to maintain integrity of the patient's identity.

Nancy Langman (2012) conducted study on increasing self-care activities for caregivers of persons with dementias to reduce burden and depression. Study conducted among 500 family care givers (280 males and 220 females). Zung Depression Self rating scale was used as tool in this study. The results indicate that support group provides emotional support (90%), information and problem solving skills for caregivers (82%) but does not necessarily reduce burden or depression or increase self-care. The meaningful significance of this intervention is reflected in the satisfaction survey completed by participants.

Schindler, Manuel; Engel, Sabine; Rupprecht, Roland (2012) conducted study centered on 131 caregivers and their recipients to investigate whether the caregiver's perceived knowledge of dementia may be a factor in reducing caregiver burden. We developed a questionnaire to measure this kind of knowledge. A significant relationship was shown between perceived knowledge 58% and caregiver burden 57%. Our multivariate analysis furthermore demonstrated that the caregivers' self-assessed state of health also has a significant influence. A second regression model included the different aspects of perceived knowledge of our questionnaire and showed that certain aspects of perceived knowledge 90%, especially concerning existing professional help services, non cognitive symptoms of dementia, and the importance of not neglecting one's own personal needs, has an positive impact on caregiver burden.

Rashmi Gupta, Vijayan Kumara Pillai , Eileen F. Levy (2012) examined the psychosocial factors that contribute to burden among Asian Indian caregivers of

the elderly in Allahabad, India. Within this context of care giving, the importance of relationship quality as a determinant of burden was examined in 259 Asian Indian families. A stress process model was utilized to explain the quality of relationship between the caregiver and the elderly persons. Another factor predicting burden was role overload. In addition, it was found that there were several indirect effects through relationship quality that predicted burden. The findings suggest that psycho educational interventions may be gainfully used to reduce burden among caregivers of elderly in India. Overall the model explained 49% of the variance in perceived caregiver burden. The comparative fit index (CFI) for the model was 0.96. As the relationship quality between the caregiver and care-recipient decreased, the level of caregiver burden increased (β=–0.489, $p \leq 0.05$). It was found that females report poorer relationship quality with elderly care-recipients (β=−0.143, $p \leq 0.05$) than males, and relationship quality was associated with greater perceived care giver burden. As expected, increases in role conflict was associated with deceases in the quality of relationship (β=−0.252, $p \leq 0.05$).

Heejung Kim, Mido Chang, Karen Rose & Sunha Kim (2011) studied of the multidimensional predictors of caregiver burden in caregivers of individuals with dementia. Data for this secondary analysis was provided by the National Alliance for Care giving, American Association of Retired Persons. The data were collected through a telephone survey of randomly selected adults in seven states in 2008 (weight adjusted n = 302). Descriptive statistics, inter-correlation analysis and a hierarchical multiple regression analysis were performed .The findings. Shows that Disease-related factors were the most significant predictors, explaining 16% of caregiver burden; these were followed by caregiver socio demographical factors and care giving-related factors (F = 21Æ28, P < 0Æ01). Significant individual predictors were impairment of activities of daily living or instrumental activities of daily living, the number of hours of care giving, use of coping strategies, co-residence, spousal status and caregiver gender (P < 0Æ05).

UO Okoye1, SS Asa (2011) study investigated the experiences of caregivers of elderly relatives growing in Nigeria. Questionnaires were distributed to 330 respondents. It result shows that there exists a significant relationship between caregiver's age and level of stress (p=0.001). The sex of care receiver, the level of education of caregivers, level of education of care receiver are all significantly related to the level of stress. Few people are prepared for the responsibilities and tasks involved in caring for the aged because of the stress involved.

K. S. Shaji, Roy K. George,1 Martin J. Prince, and K. S. Jacob (2009) conducted study on behavioral symptoms and family care giver burden. The nature and prevalence of Behavioral and Psychological Symptoms of Dementia in a community sample of patients with dementia was assessed by a clinician. The impact of these symptoms on the caregiver was assessed by measures of burden of care and the psychological well being of the caregiver. Another rater carried out these assessments independently. Prevalence of Behavioral and Psychological Symptoms of Dementia was very high and they were more common in patients with Alzheimer's disease than patients with Vascular Dementia. They were rated as troubling to most caregivers. Caregiver burden was associated with adverse effects on the mental health of the family care giver.

2.3 STUDIES RELATED TO OTHER INTERVENTIONS FOR FAMILY CARE GIVERS AMONG DEMENTIA CLIENTS.

Cynthia M. Castro, Sara Wilcox, PhD, Paula O'Sullivan, PhD, Kellie Baumann, BA and Abby C. King, (2012) conducted study factors related to retention and adherence to an exercise program for women caregivers **of** 100 sedentary women (average age = 62 years) caring for relatives with dementia were randomly assigned to an exercise program or an attention control (nutrition education) condition. Participants in the exercise condition received 12 months of home-based exercise counseling to achieve at least four exercise sessions per week, for at least 30 minutes per session. Adherence was tracked through monthly exercise logs, validated in a subsample by ambulatory heart rate and motion

monitors. Participants also completed a psychosocial questionnaire battery at baseline and 12 months after randomization. It shows that Participants achieved a 12-month average exercise adherence rate of 74% (ie, three exercise sessions per week) with an average of 35 minutes per session. At 12 months, the exercise condition demonstrated increased knowledge of the benefits of exercise and increased motivational readiness for exercise compared with the nutrition education condition. Both groups significantly improved in perceived stress, burden, and depression from baseline to posttest. Women who were older, less depressed, and more anxious at baseline showed better program retention, and lower baseline depression was associated with better exercise adherence.

Adam L. Bank, Soledad Arguelles, Mark Rubert, Caril Eisdofer , and Sara J.Czaja. (2010) conducted telephone-based support groups in ethnically diverse dementia caregivers. Design and Methods: Participants were 41 White American and Cuban American dementia caregivers participating at the Miami site of the Resources for Enhancing Alzheimer's Caregiver Health (known as REACH) program. Support groups were conducted over the telephone in English and Spanish as appropriate. It shows that 81% of the participants found the group "valuable," largely because of the social and emotional support and useful information obtained from other group members. The majority of caregivers also reported that their participation had increased their knowledge (90%) and skills (87%) as caregivers.

Simon Douglas, Ian James and Clive Ballard (2010) reviewed and examine current non-pharmacological approaches. It highlights the more traditional treatments such as behavioral therapy, reality orientation and validation therapy, and also examines the potential of interesting new alternative options such as cognitive therapy, aromatherapy and multisensory therapies. The current literature is explored with particular reference to recent research, especially randomized controlled trials in the area. Although many non-pharmacological treatments have reported benefits in multiple research studies, there is a need for further reliable and valid data before the efficacy of these approaches is more widely recognized.

Silvia Sörensen, Martin Pinquart, Dr Habil B and Paul Duberstein (2011) conducted this meta analysis study was to determine the effectiveness of interventions for family caregivers of older adults. Design and Methods: Meta-analysis was used to synthesize the effects of 78 caregiver intervention studies for 6 outcome variables and 6 types of interventions. It revealed that combined interventions produced a significant improvement of 0.14 to 0.41 standard deviation units, on average, for caregiver burden, depression, and subjective well-being, perceived caregiver satisfaction, ability/knowledge, and care receiver symptoms. Intervention effects were larger for increasing caregivers' ability/knowledge than for caregiver burden and depression. Psycho educational and psychotherapeutic interventions showed the most consistent short-term effects on all outcome measures. Intervention effects for dementia caregivers were smaller than those for other groups. The number of sessions, the setting, care receiver age, caregiver age, gender, type of caregiver–care receiver relationship (spouse vs. adult child), initial burden, and study characteristics moderated the observed effects

Alison Marriott, Catherine Donaldson, Nicholas Tarrier, Alistair Burns, (2010) evaluated whether family intervention reduces the subjective burden of care in family care givers of patients with dementia and produces clinical benefits in the patients. A prospective single-blind randomized controlled trial with 3-month follow-up in which the experimental group received family intervention and was compared with two control groups. It reveals that there were significant reductions in distress 67% and depression77% in the intervention group compared with control groups at post-treatment and follow-up. There were significant reductions in behavioral disturbance78% at post-treatment and an increase in activities at three months in patients in the intervention group. Based on an improvement on the General Health Questionnaire resulting in a family care givers converting from a case to a non-case, the number to treat was three immediately post-treatment and two at follow-up.

CONCEPTUAL FRAME WORK

All research studies have the frame work of back ground knowledge that provide the foundation for the study. The frame work serves to organize the study by placing it in the content of existing related knowledge as well as providing a context with in to interpret the result of the study.

Concept is defined as a complex mental formation of an object, promptly on or even experience. Theories and conceptual models are primary means providing a conceptual context for the study.

Conceptualization is a process of forming ideas, which are utilized and forms conceptual frame work for the development of research design. It helps to investigator to know what about data need to be collected and given direction to the entire research process.

The conceptual model selected for this study is based on "Widenbach's helping arts of clinical nursing theory" adopted by Emestine Widenbach's in 1964, which aims to assess the effectiveness of psycho education module on knowledge regarding dementia among care givers of old age people residing in selected community area.

The conceptualization of nursing practice according to the theory has three components which are as follows.

1. Identification of the patient need to help
2. Ministration of needed help
3. Validation of action taken to meet the needed help.

STEP –I- IDENTIFICATION

It refers to the determination of the clients need for help by the process of sample selection on the basis of inclusion criteria followed by assessing level of pain perception by using "Pre assessment scale of knowledge of dementia" among care givers of old age people residing in selected community area.

STEP –II- MINISTRATION

It refers to the provision of needs help to fulfill the identified need.

It consist of three components

1. Central purpose
2. Prescription
3. Realities

CENTRAL PURPOSE:

It refers to the effective of psycho education module on improving knowledge regarding dementia among care givers of old age people residing in selected community area.

PRESCRIPTION:

A prescription refers to the activity which specified both nature of action and the thinking that will leads to fulfillment of nurse's central purpose. This include the psycho educational module on general information, personal hygiene, eating habits, maintaining environment to the client, drug follow up and home care, among the care givers of old age dementia people residing in selected community area.

REALITIES:

It indicates the factors that influence the nursing action this include 5 realities

1. **AGENT**

   The investigator - Community health psychiatric nurse.

2. **RECIPIENT**

   The care givers of old age dementia people residing in selected community area..

3. **GOAL**

   Improve the knowledge of dementia disease condition,

4. **MEAN**

   The psycho educational module on general information, personal hygiene, eating habits, maintaining environment to the client, drug follow up and home care, among the care givers of old age dementia people

5. **FRAMEWORK**

   It refers to the facilities in which nursing care is practical which indicate selected community area in Chennai.

STEP- III - VALIDATION:

Validation refers to the collection of evidence that shows the care givers need have been met that the knowledge, care of dementia and functional ability has been restored as a direct result of nurse's action. In this study validation includes improve the level of knowledge among care givers of old age dementia people residing in selected community area.

Modified conceptual frame work of Widenbach's helping art of clinical nursing theory -1964

CENTRAL PURPOSE

Assess the effectiveness of psycho education module on knowledge regarding dementia among care givers of old age people residing in selected community area.

Step-I
Identification

Step-II
Ministration

Step-III
Validation

Collect the demographic details and Assess the knowledge level of dementia in General, personal hygiene, Eating habits,Maintaining environment, Drugs and Follow up and Home care

Prescription
Assess the level of knowledge of dementia disease condition among Care givers of old age people

P

Recipient
Care givers of old age people with dementia residing in selected community area

Agent
Investigator

Frame work
Selected community area

Means
Dementia knowledge improving psycho education

Realitie

of care givers of ole age people

P

EFFECT OF PSYCCHO EDUCATION

Moderate knowledge acquired by Care givers of old age people group

te knowledge by Care givers e people group

CHAPTER - III

METHODOLOGY

This chapter consists of the research design, the variable of the study, the setting, and the population sample, sample size, sampling technique, selection criteria, development and description of tool, content validity, pilot study, reliability, data collection procedure and plan for data analysis.

3.1. RESEARCH APPROACH

The research approach used for this study is Interventional approach. This study consists of pre test, psycho education module on knowledge regarding dementia and post test method.

3.2. RESEARCH DESIGN

The research design selected for this study is one group pre test - post test design

PRE TEST	INTERVENTION	POST TEST
O1	X- PSYCHO EDUCATION MODULE ON KNOWLEDGE REGARDING DEMENTIA	O2

O1 -Pre test to assess the level of knowledge regarding dementia among the family care givers of old age residing in selected community area.

X –Psycho education module on knowledge regarding dementia

O2- Post test to determine the level of knowledge regarding dementia among the family care givers of old age residing in selected community area.

RESEARCH VARIABLES:

Variables are characteristics that vary among the subjects being studied

Dependent Variable

The level of knowledge regarding dementia among the family care givers of old age resided in selected community area Choolai.

Independent variable

Psycho education on knowledge of dementia disease intervention module (includes improving knowledge regarding dementia disease, personal hygiene, eating habits, maintaining environment, person centered care, care interactions, enriching the person's life, understanding behaviors, interacting with families, direct care worker self care to the family care givers and drugs and follow-up care)

Attribute Variables

Such as age, sex, education, religion, occupation, religion, marital status, type of family, income group, source of information, and relationship to patient.

3.4 .SETTING OF THE STUDY

The study was conducted in selected community area Choolai and its surroundings, Chennai-20. This area is within the city, total families in that area is 6500 among which have old age people were around 300 -450 etc.

3.5. POPULATION

The population of the study was family care givers of old age who was residing in selected community area Choolai, Chennai-20.

3.6. SAMPLE

The size of the sample study was 60 family care givers of old age those who fulfilled the inclusion criteria residing in selected community area Choolai, Chennai-20.

3.7. SAMPLE SIZE

The sample size of the study is 60 family care givers.

3.8. SAMPLING TECHNIQUES

The technique used was simple random technique. The sample frame made based on the inclusion and exclusion criteria. After the frame was made simple random technique (Lottery method) was used to select the subjects for the study.

3.9. CRITERIA FOR SAMPLE SELECTION

INCLUSION CRITERIA:

- Care givers of old age people with dementia in the age group of 60-80 years.
- Care givers of old age people who are available during the data collection period.
- Care givers of old age people who are willing give consent for the study.
- Care givers of old age people who are able to read Tamil

EXCLUSION CRITERIA:

- Care givers of old age people who are health care professionals.
- Care givers of old age people who had previous educational programs on dementia care.

3.10. DEVELOPMENT AND DESCRIPTION OF THE TOOL

The tool comprises of 2 sections

Section– A: Socio demographic Data

It consists of age, gender, education of family care givers, occupation, religion, marital status, type of family, income group, source of information, and relationship with patient.

Section B

Knowledge questionnaire comprised of 28 items to evaluate knowledge of dementia among family care givers of old age people residing in selected community area.

3.11. SCORING TECHNIQUES

(Yes =4; No =3; Not sure =2; Don't know =1)

S.No	Raw Score	Percentile
1	108	95%
2	100	90%
3	96	85%
4	86	75%
5	75	65%
6	67	60%
7	55	50%

The knowledge on dementia questionnaire is a investigator made instrument that yields a direct measure of how the family care giver deficit on knowledge aspect. This tool consist 28 items that are specific to academically –

related test situations and environments. The investigator modified questionnaire comprised of four point Likert scale was used to obtain the participants responses.

3.12. VALIDITY OF THE TOOL

Validity refers to the degree with which an instrument measures what it is supposed to be measuring (Polite and Hungler 2013) Since it is a investigator made tool further standardization was required which is obtained from the nursing experts, psychiatric medical officer, clinical psychologist. The tool was translated in Tamil and re translated into English by language experts.

3.13. PILOT STUDY

Pilot study was conducted during the first week of July 2.07.2014 to 12.07.2014 to examine the feasibility, and practicability of this study. Pilot study was conducted among 5 family care givers those who were residing in choolai at Chennai. It revealed that the study was feasible. Data were analyzed to find out the suitability of statistical method.

3.14. RELIABILITY OF TOOL

The knowledge on dementia a investigator made inventory questions had demonstrated very good reliability. A test retest correlation r=0.78 which signifies that the tool is reliable

3.15. DATA COLLECTION PROCEDURE

The data collection procedure was conducted after obtaining permission from Ethical committee for four weeks. The investigator selected variety of families with old age persons at Choolai, Chennai. Before conducting the study, the investigator obtained permission from the Chief Corporation Medical Officer and Medical officer of urban centre. The study period was between 1.07.14 to 28.07.14.

Phase I

This Choolai urban community comprises of 6500 families among which 200-300 families had old age persons, they were randomly assessed for

knowledge deficit on dementia by using knowledge assessment scale, it took 30-45 minutes to complete the assessment form, out of 250 families 70 family care givers of old age were identified with dementia disease condition.

Phase II

In this phase the investigator obtained collected history of 70 family care givers of old age who were identified with dementia disease condition; like poor in knowledge of dementia disease condition, personal hygiene, eating habits, maintaining environment for the client, follow up and home care. The obtained scores 86-55 were moderate and below 50 were poor on knowledge of dementia diseases condition. Investigator selected 60 family care givers of old age by lottery method. Those who fulfilled the inclusion criteria were selected for psycho education module on knowledge intervention. During the study, dropped out family care givers of old age were 10 in which four of them were sick, two were not willing and four is not willing to participate. Following the assessment, 4 weeks of psycho education module on knowledge intervention was administered as a teaching method, group discussion and demonstration session were conducted for 30- 45 minutes daily In the 4 Th week post level of knowledge was assessed for each care givers of individual.

1. First day – Submitting a letter to Corporation Health Officer
2. Second day _ Introduction about study
3. I st session _ Improving knowledge on Dementia
4. II nd session _ Person-centered care,
5. III rd session – Care interactions
6. IV th session _ Enriching the person's Life
7. V th session – Understanding behaviours
8. VI th session – Interacting with families
9. VIII Th session _ Direct care worker self-care
10. IXth session _ Putting it, all together ends
11. After two week – Post evaluation will be conducted

3.16. PLAN FOR DATA ANALYSIS

Data were analyzed according to the objectives of the study and both descriptive and inferential statistics were used

- Analysis of the demographic variables were given in frequencies and with their percentage
- "t" test was used to determine the difference between the pretest and posttest score in term of knowledge deficit on dementia.
- Chi square test was used to associate Post test scores with selective socio demographic variables.

RESEARCH COMMITTEE APPROVAL

The proposed study was conducted after approval from the dissertation committee of the college of Nursing, Madras Medical College, Chennai-03. The permission was obtained from The Dean and principal of college of Nursing.

Research approach
Evaluative approach

Research Design
Pre experimental one group pre test and post tes

Sample size an Sampling technique
N= 60, Non probability purposive sampling technique

Settings
Selected community area, Choolai, Chennai-20

Research variables

Independent variables- Psycho education on knowledge of dementia disease intervention **Dependent variables**- Knowled

Data collection instrument
Socio demographic profile and Knowledge assessment of Dementia diseas

Data collection analysis and interpretation
Descriptive and inferential analysis

Findings and Conclusion of the study

3.17. PROTECTION OF HUMAN SUBJECTS

WRITTEN CONSENT FORM

The researcher proposal was approved by the ethical committee experts prior to the pilot study and permission for the main study was obtained from Chennai corporation Health officer. and the Urban health post Medical officer,

An informed consent (Appendix) form each study subject was obtained before starting the data collection and assurance was given to the study subject, that confidentiality and privacy of each individual would be maintained.

SCHEMATIC REPRESENTATION OF THE STUDY

CHAPTER-IV

DATA ANALYSIS AND INTERPRETATION

Interpretation of data

This chapter deals with the interpretation of data collected from 60 geriatrics caregivers to identity the psychological well-being. They were selected as per criteria for selection. The data collected were grouped and analyzed by using a descriptive and inferential statistical method.

"A study to assess the effectiveness of psycho education module on knowledge regarding dementia among care givers of old age people residing in selected community area

1. To identify the socio demographic variables of the care givers.
2. To assess the knowledge regarding Dementia before psycho education intervention.
3. To assess the knowledge regarding Dementia after psycho education intervention.
4. To evaluate the effectiveness of the psycho education intervention.
5. To associate the level of knowledge with selected demographic variables

Objective 1: To identify the socio demographic variables of the care givers.

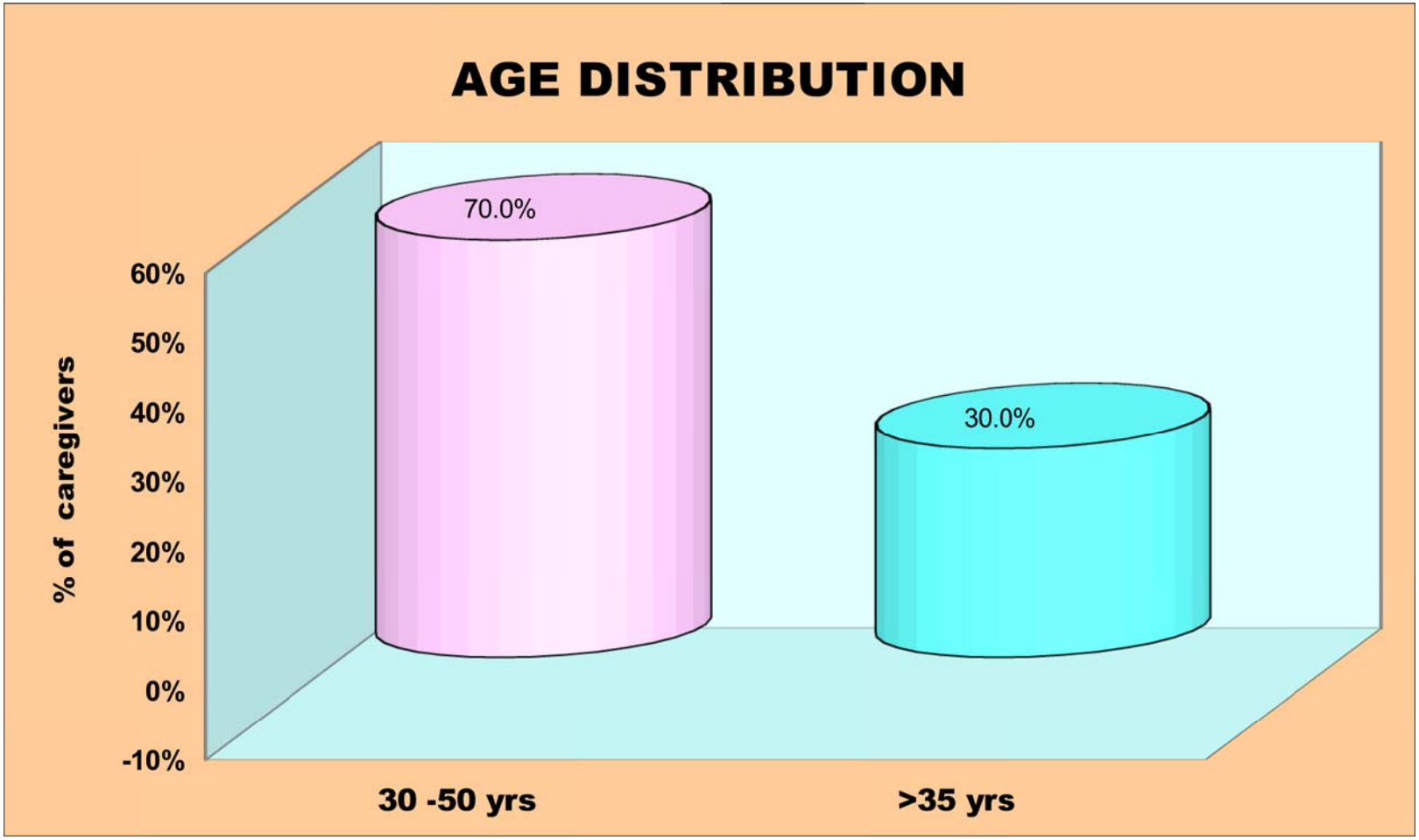
Table 1: DEMOGRAPHIC PROFILE

Demographic variables		No. of caregivers	%
Age	30 -50 yrs	42	70.0%
	51 -70 yrs	18	30.0%
Gender	Female	60	100.0%
Education	No formal education	12	20.0%
	Primary school	36	60.0%
	High school	12	20.0%
Occupation	Private	30	50.0%
	Business	30	50.0%
Religion	Hindu	48	80.0%
	Muslim	6	10.0%
	Christian	6	10.0%
Marital status	Married	48	80.0%
	Single	12	20.0%
Type of family	Joint family	12	20.0%
	Nuclear family	48	80.0%
Income	> Rs. 20000	6	10.0%
	Rs.5,000-10,000	48	80.0%
	<Rs.5000	6	10.0%
Source of information	Mass media	6	10.0%
	Health personnel	18	30.0%
	Friends / Relative	36	60.0%

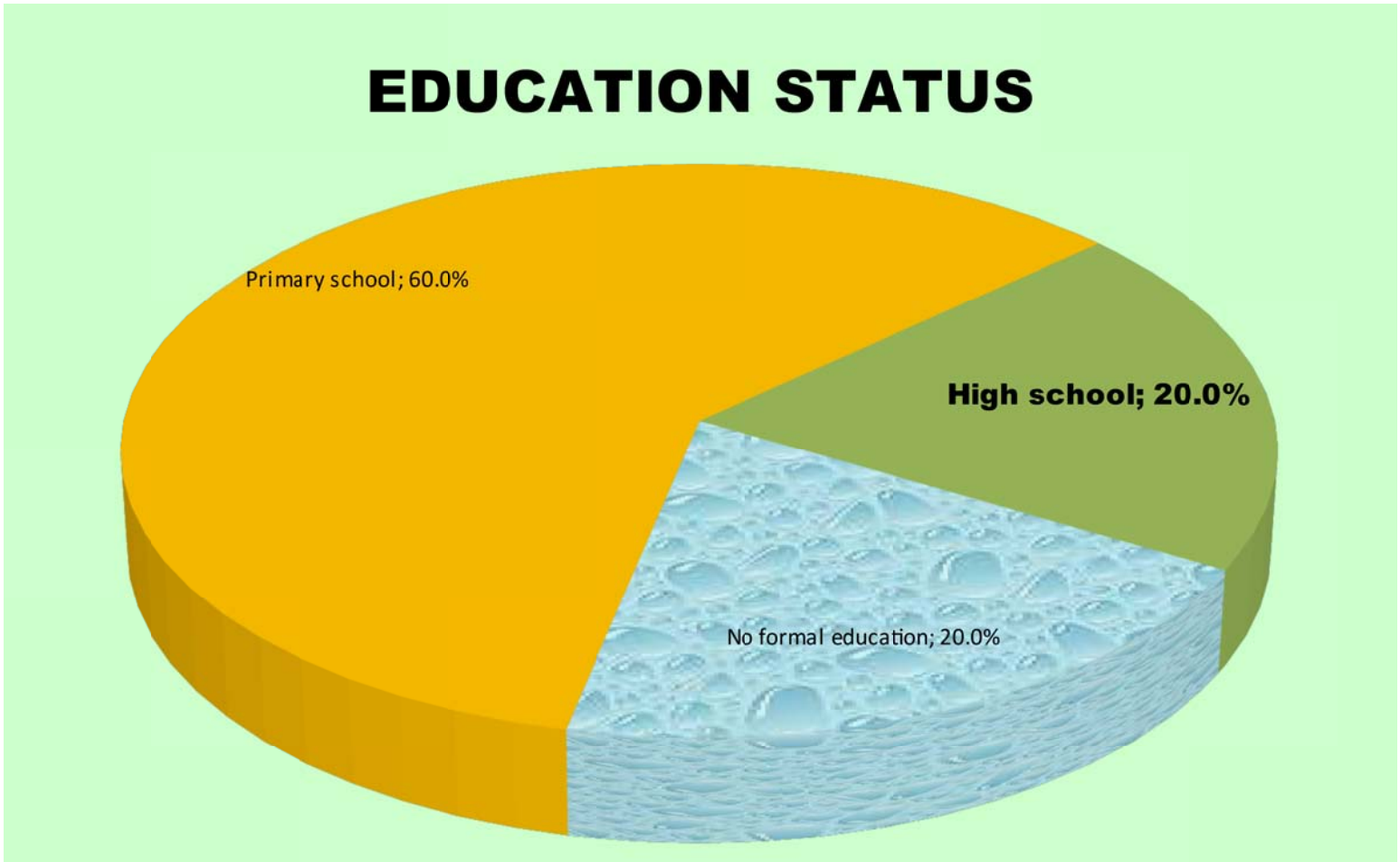
Relationship to patient	Spouse	30	50.0%
	Daughter/daughter-in-law	18	30.0%
	Other relative	12	20.0%
Caregiver relationship with patient	Co-caregiver	60	100.0%
Suffering from dementia	10-5years	34	56.7%
	2 -5years	26	43.3%

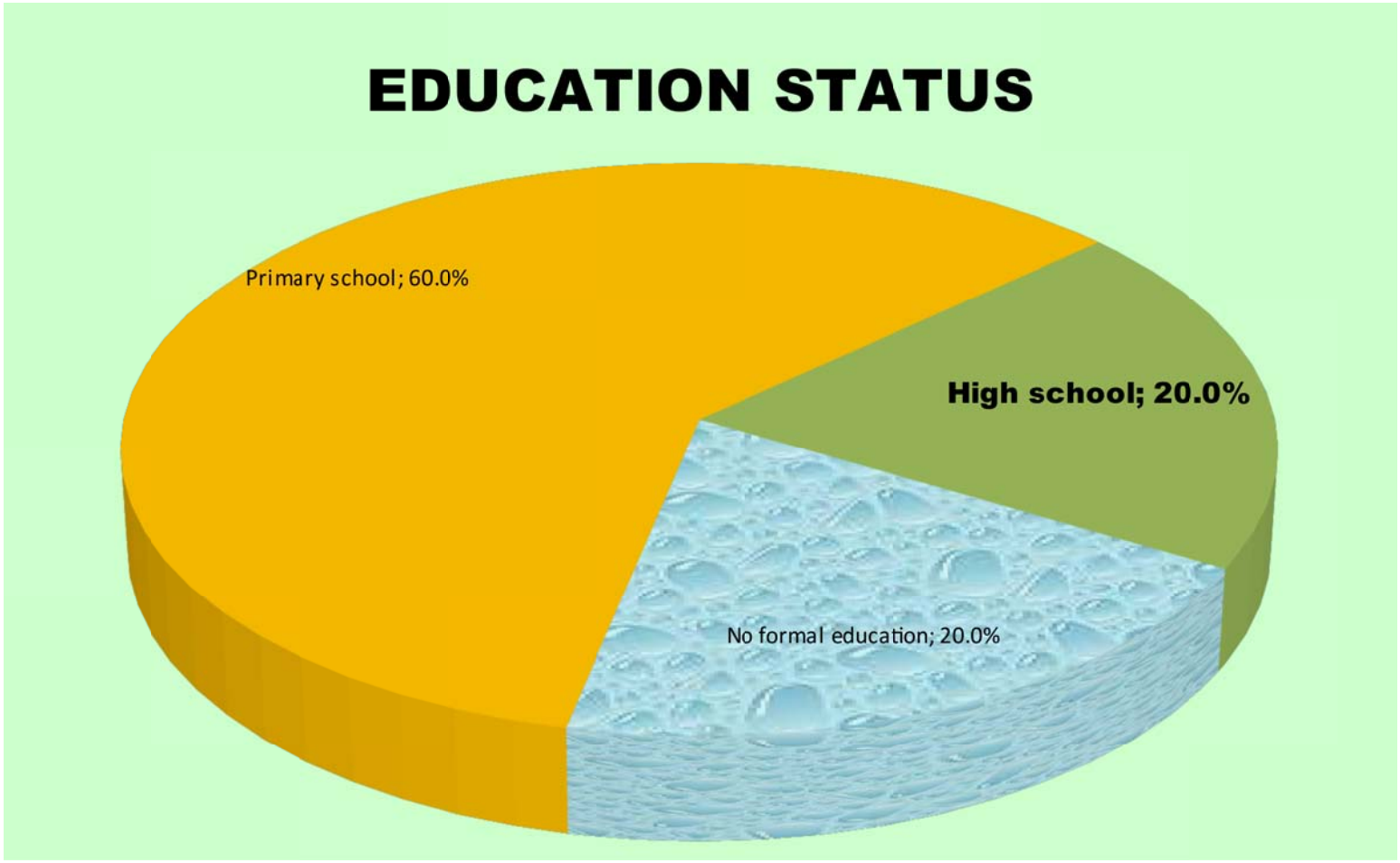
Table 1 shows the demographic information of caregivers those who are participated for the following study on "A study to assess the effectiveness of psycho education module on knowledge regarding dementia among care givers of old age people residing in selected community area"

The above table reveals that the age wise most of the care givers belongs to 30 -50 years were 70.0%, gender wise female care takers were 100%, education of care givers highest of them were primary school 60.0%, occupation of care givers equally of them were business and private was 50.0%, most of them were married were 80%, type of family was majority of them belongs nuclear family 80.0%, income wise highest of them were middle income group 5000 -10000 80.0%, source of information gathered from highest by their spouses were 50.0%, co care giver was female care takers were 100%, and finally suffering from dementia most of them was suffered for 10- 5 years were 56.7%.

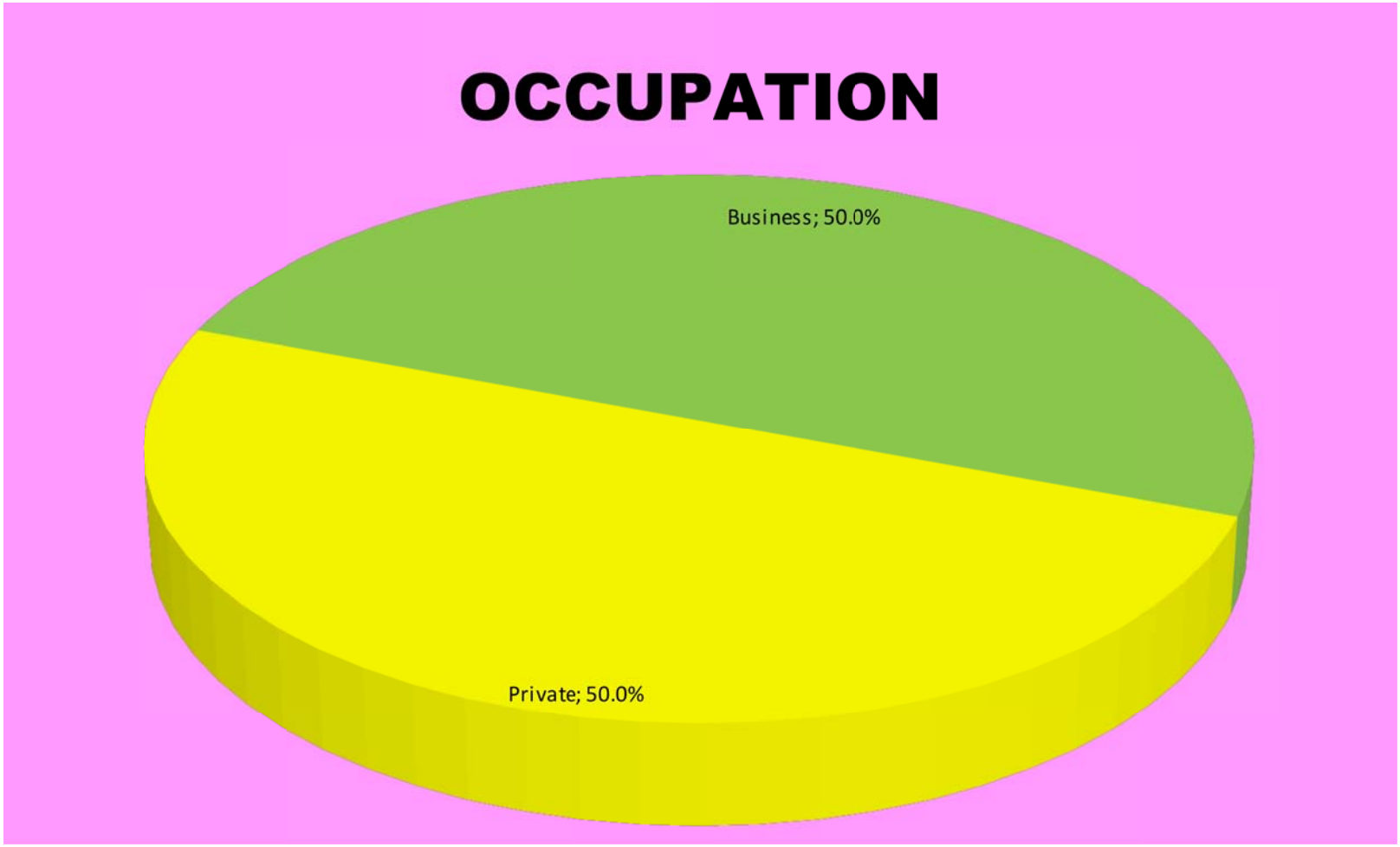


4.1 The above figure illustrate that age wise most of the care givers belongs to 30 -50 years were 70.0%.

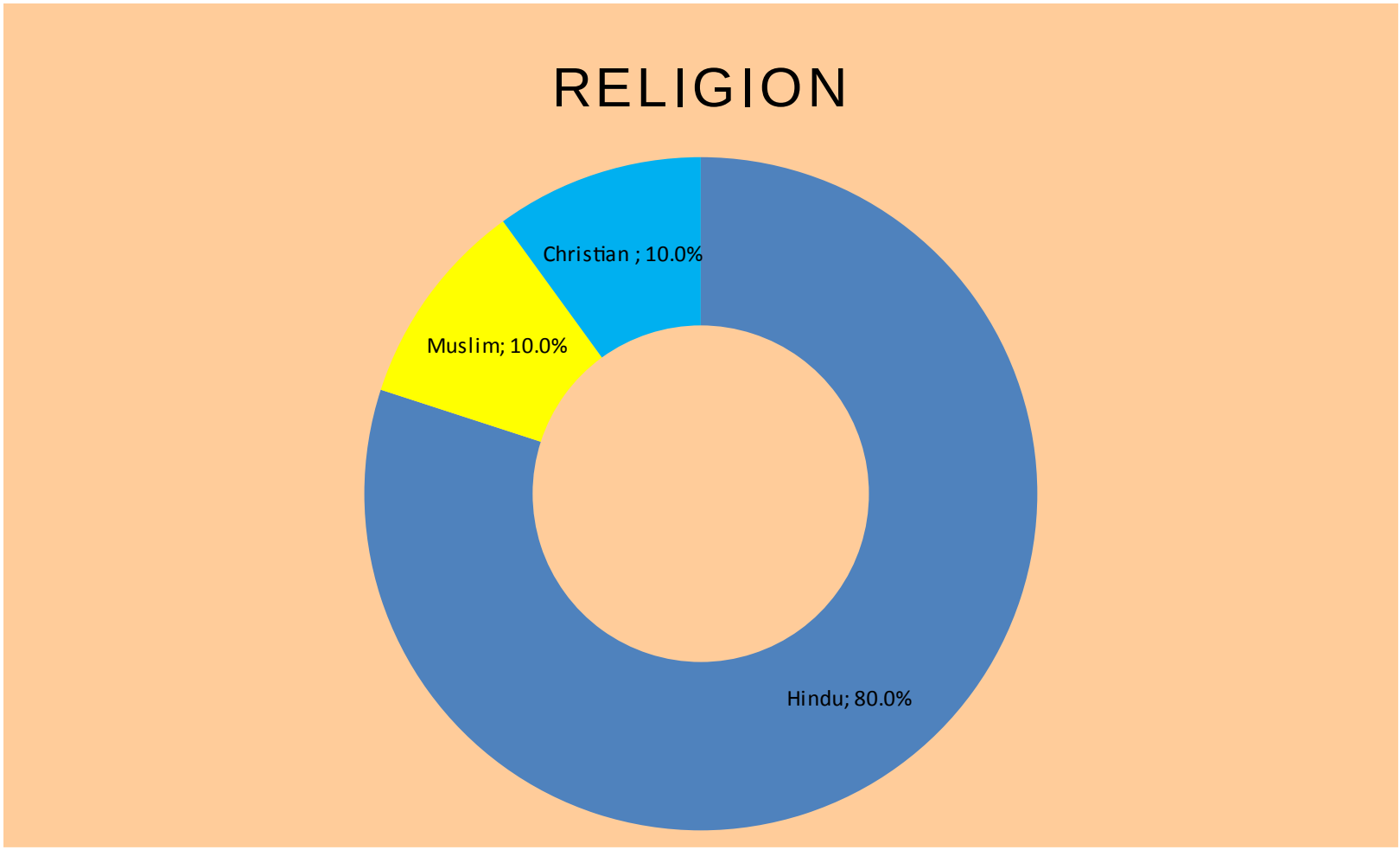

EDUCATION STATUS
Primary school; 60.0%
High school; 20.0%
No formal education; 20.0%



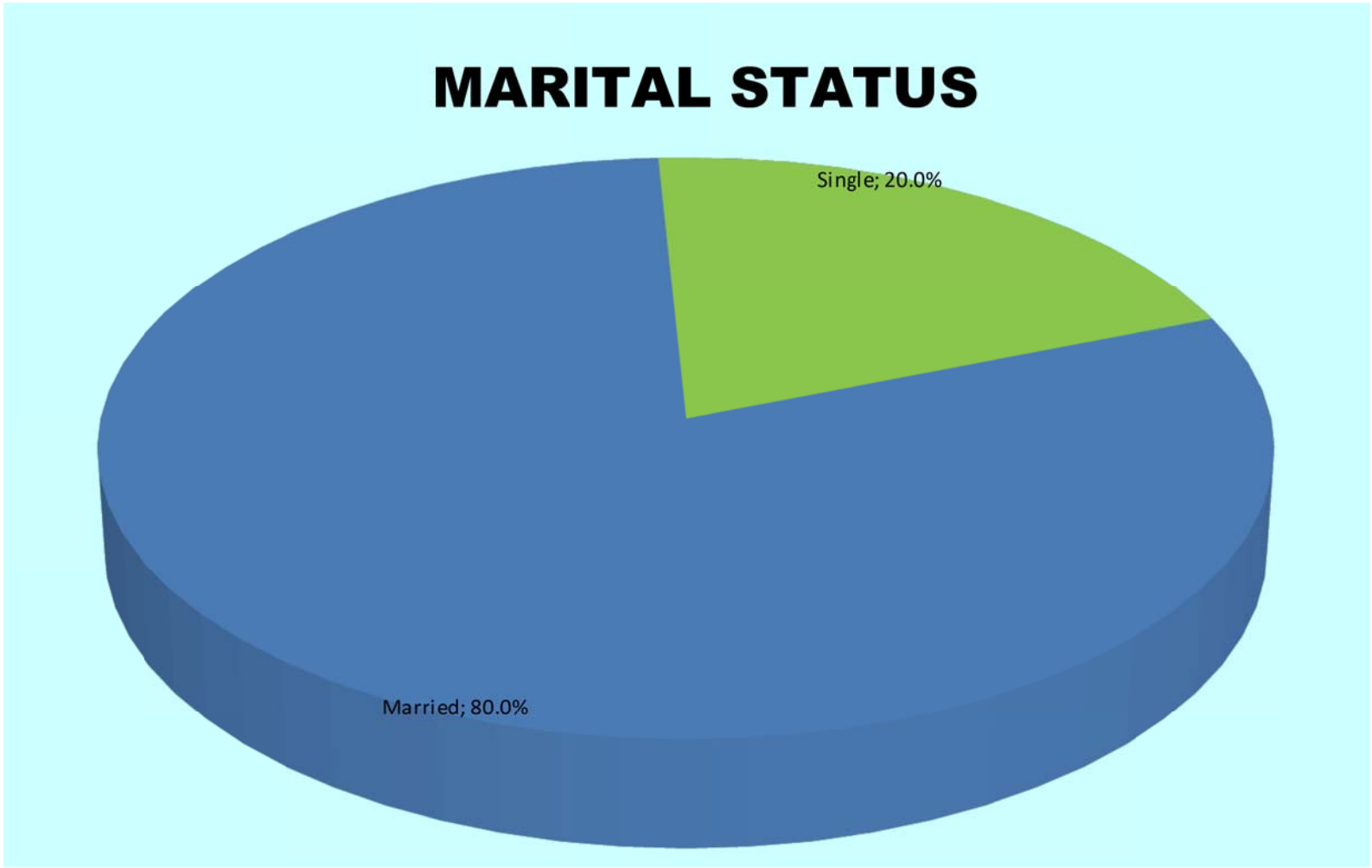
4.2 The above figure illustrate that education of care givers highest of them were primary school 60.0%



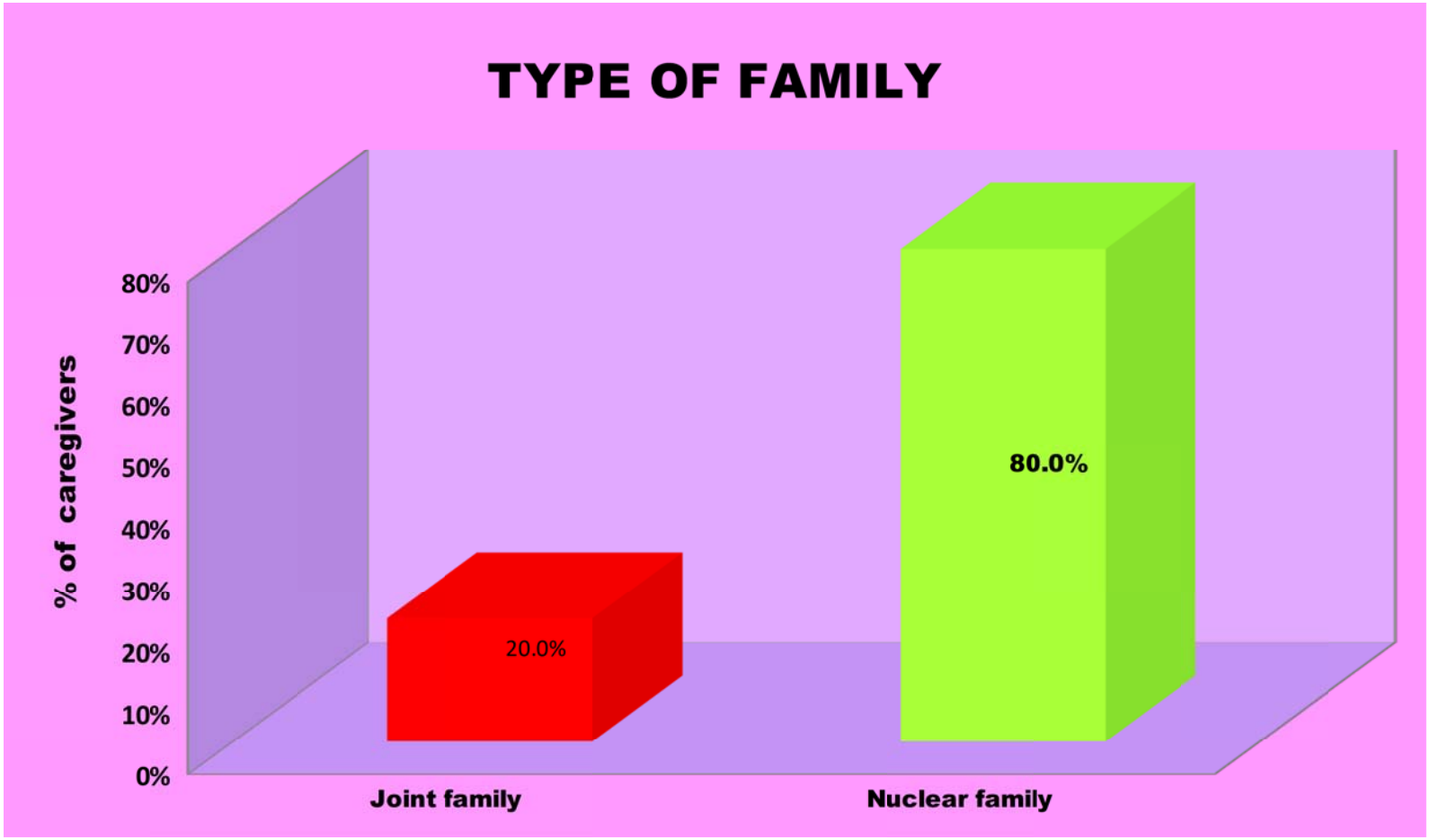
4.3 The above figure illustrate that occupation of care givers equally of them were business and private was 50.0%



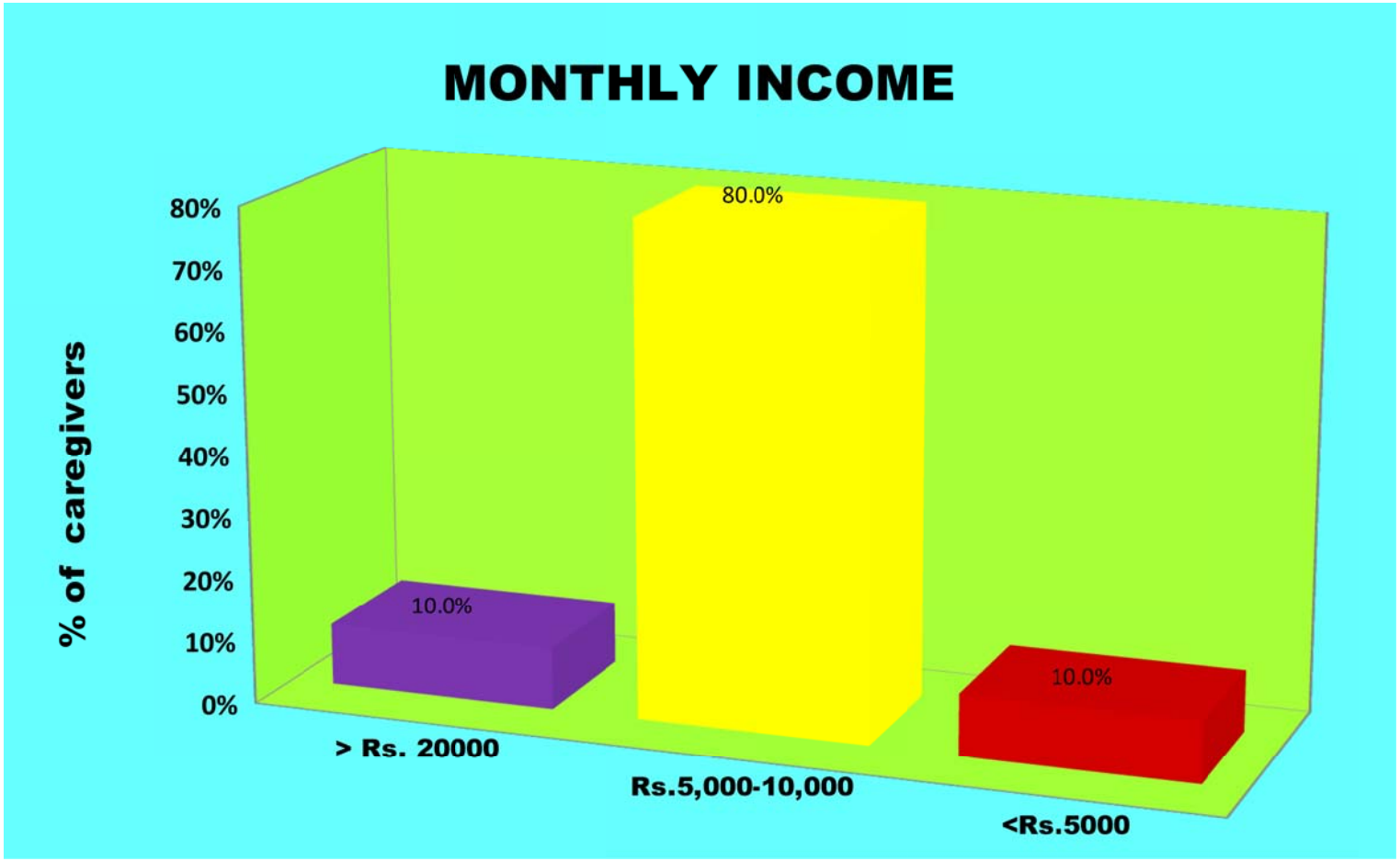
4.4 The above figure illustrate that majority of them were Hindu religion 89 %



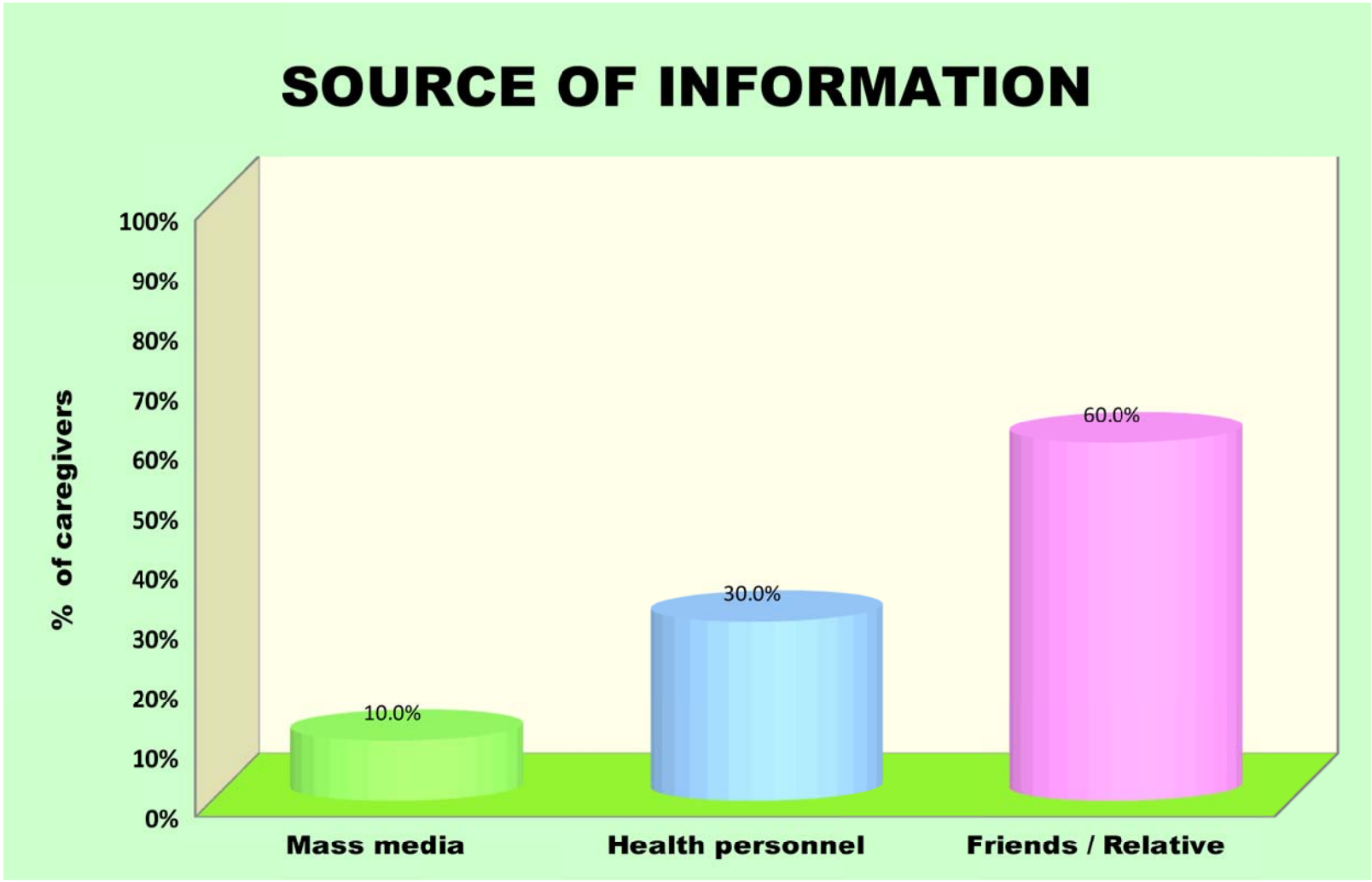
4.5 The above figure illustrate that most of them were married were 80%,



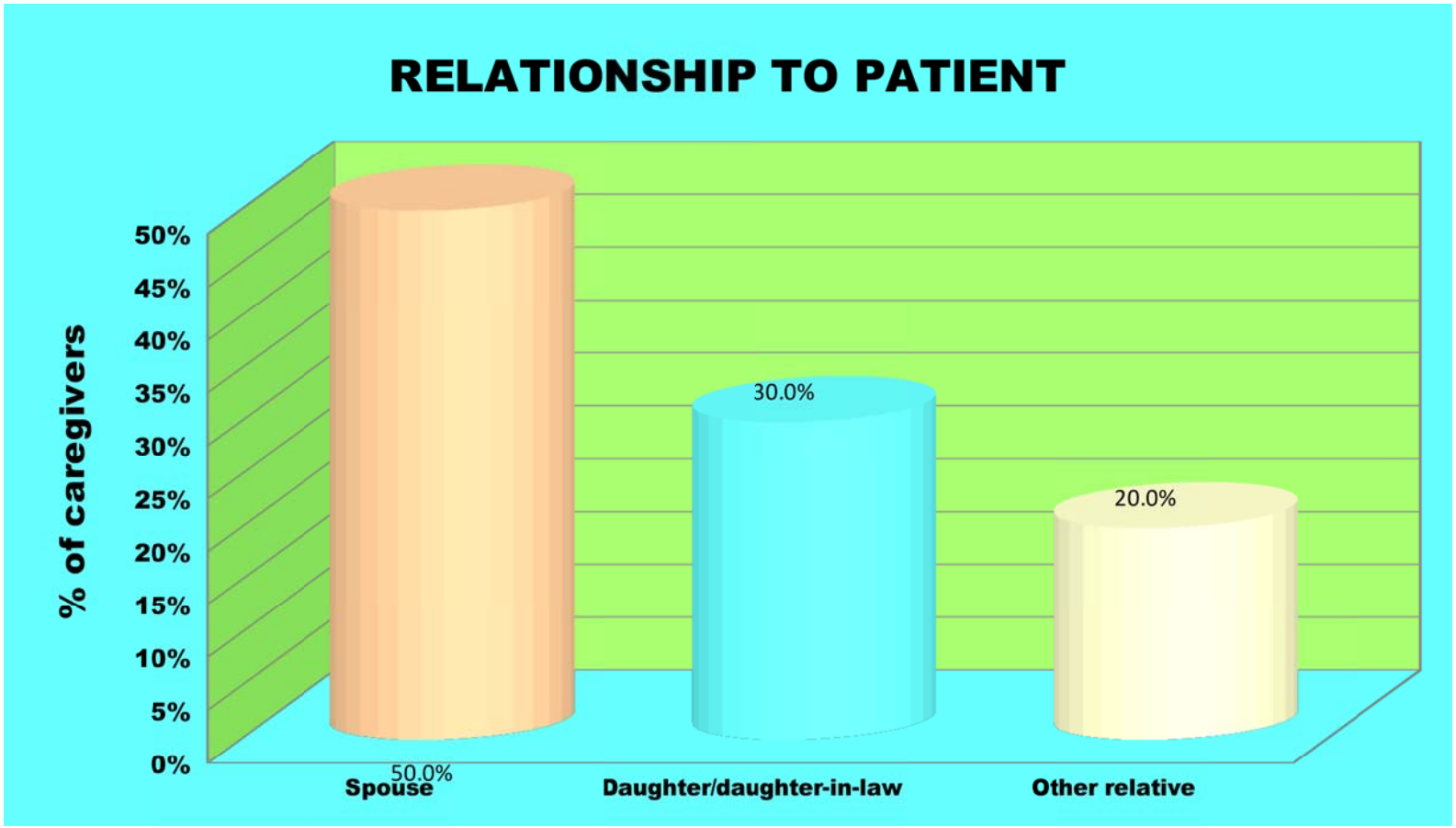
4.6The above figure illustrate that type of family was majority of them belongs nuclear family 80.0%,



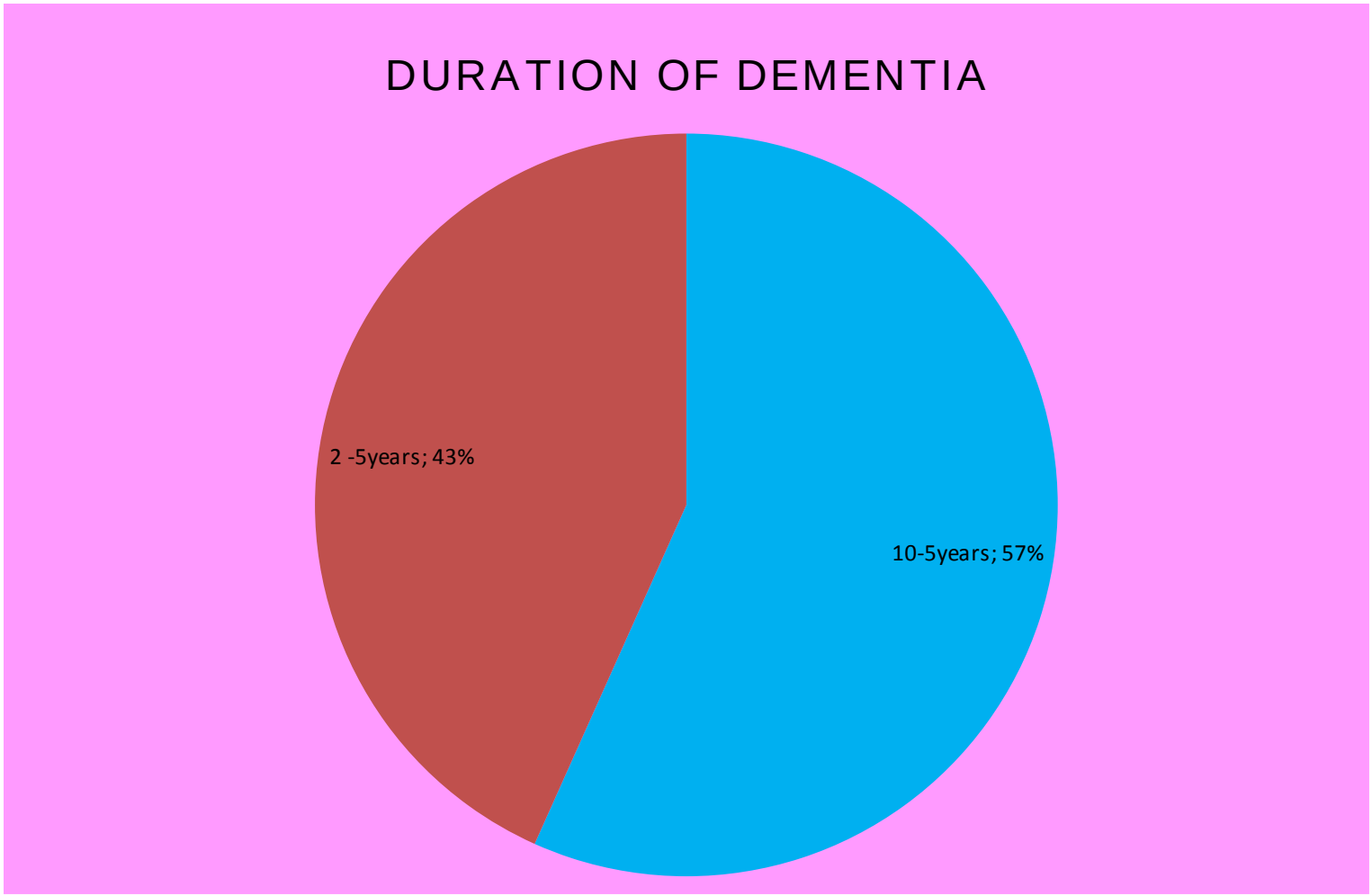
4.7 The above figure illustrate that monthly income wise highest of them were middle income group between 5000 -10000 80.0%,


SOURCE OF INFORMATION
% of caregivers
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
10.0%
30.0%
60.0%
Mass media
Health personnel
Friends / Relative

4.8The above figure illustrate that source of information gathered from highest by their spouses were 60.0%,



4.9The above figure illustrate that care givers no's of them were by spouse were50%



4.9The above figure illustrate thatclients suffer with dementia for the period of 10-5 years were 57%

Objective 2: To assess the knowledge regarding Dementia before psycho education intervention

Table 2: EACH DOMAINWISE PERCENTAGE OF PRETEST KNOWLEDGE

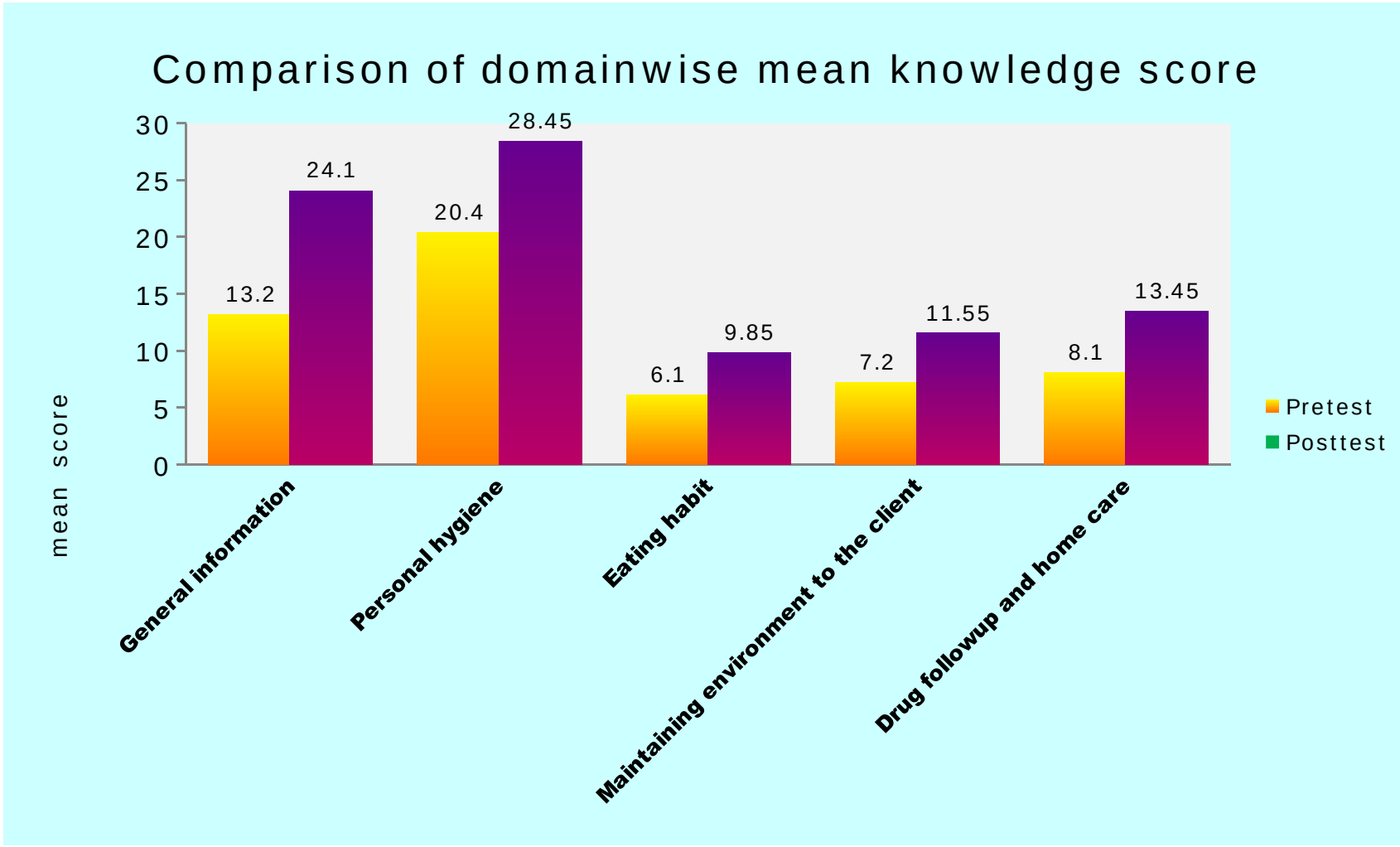
Knowledge on	No. of questions	Min – Max score	Knowledge Score		
			Mean score	SD	% of mean score
General information	8	8 -32	13.2	2.38	41.3%
Personal hygiene	9	9 -36	20.4	2.68	56.7%
Eating habit	3	3 -12	6.1	1.23	50.8%
Maintaining environment to the client	4	4 -16	7.2	2.38	45.0%
Drug follow up and home care	4	4 - 16	8.1	1.65	50.6%
Total	28	28 -112	55.0	4.46	49.1%

Table 2 assess the knowledge regarding dementia among care givers of old age people residing in selected community area before psycho education module. Maximum knowledge score in **personal hygiene** (56.7%) and minimum knowledge score in **general information** (41.3%). Overall they are having 49.1% of knowledge score.

Level of knowledge	Score	%
Inadequate	0- 56	≤50%
Moderate	57 -84	51- 75%
Adequate	85- 112	-100%

Level of knowledge	No. of caregivers	%
Inadequate	24	40.0%
Moderate	32	53.3%
Adequate	4	6.7%
Total	60	100

Table 3 shows the level of


Comparison of domainwise mean knowledge score
mean score
30
25
20
15
10
5
0
13.2
24.1
20.4
28.45
6.1
9.85
7.2
11.55
8.1
13.45
General information
Personal hygiene
Eating habit
Maintaining environment to the client
Drug followup and home care
Pretest
Posttest

4.10The above figure illustrate care givers having knowledge on personal hygiene 28.45% &general information 24.1%

Objective 3: To assess the knowledge regarding Dementia after psycho education intervention

Table 4: EACH DOMAINWISE PERCENTAGE OF POSTTEST KNOWLEDGE

Knowledge on	No. of questions	Min – Max score	Disability score		
			Mean score	SD	% of mean score
General Information	8	8 -32	24.1	1.31	75.3%
Personal Hygiene	9	9 -36	28.45	1.41	79.0%
Eating Habit	3	3 -12	9.85	.80	82.1%
Maintaining Environment to the client	4	4 -16	11.55	1.21	72.2%

Drug follow-up and home care	4	4 - 16	13.45	.93	84.1%
Total	28	28 -112	87.40	3.30	78.0%

In Post-test Maximum knowledge, score in personal hygiene (79.0%) and minimum knowledge score in general information (75.3%).eating habit (72.2%), Maintaining Environment to the client (72.2%) and Drug follow-up and home care (78.0%)

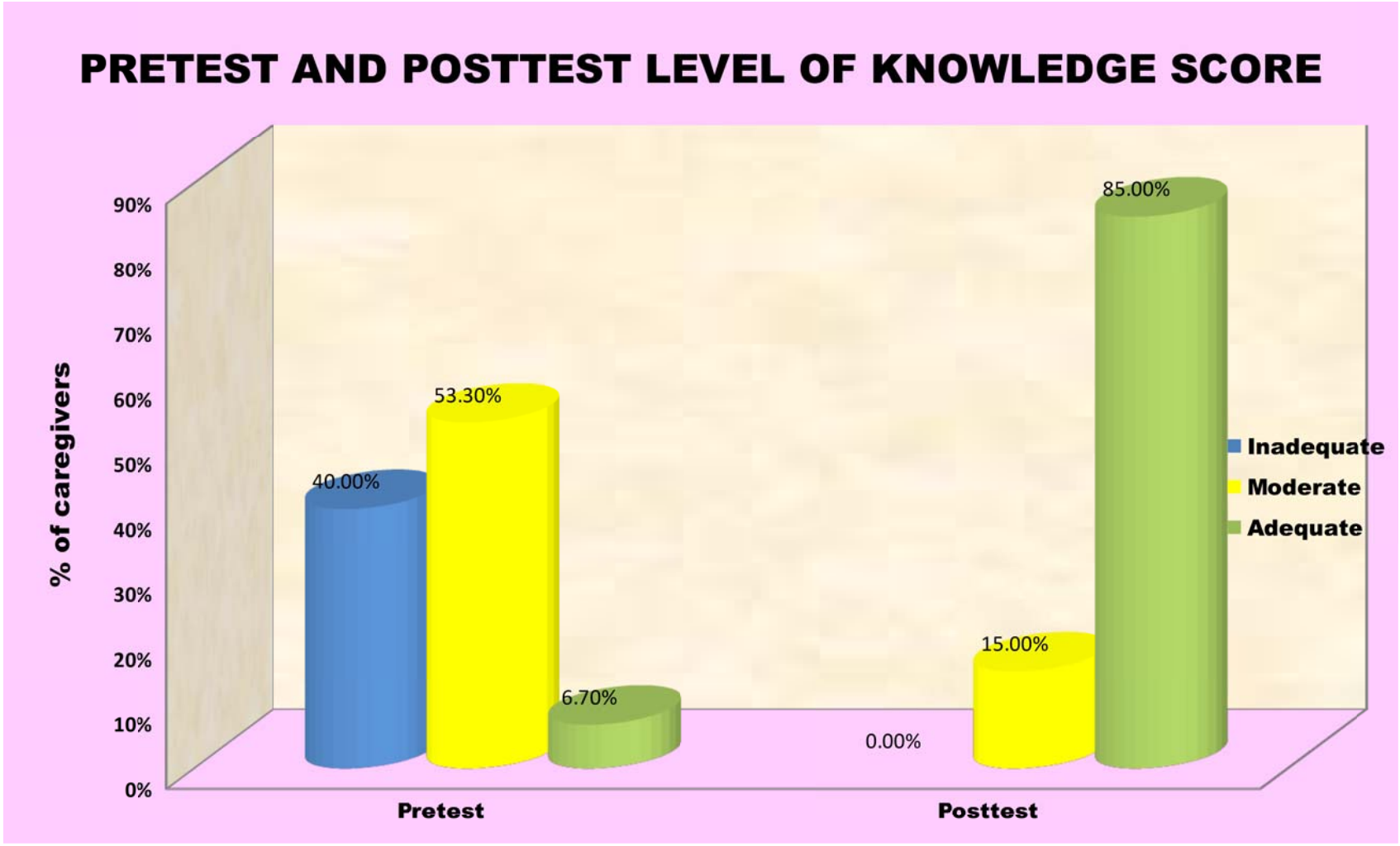
Table 5: POSTTEST LEVEL OF KNOWLEDGE

Level of knowledge	**No. of caregivers**	**%**
Inadequate	0	0.0%
Moderate	9	15.0%
Adequate	51	85.0%

Total	**60**	**100%**

Table 5 shows the level of knowledge after psycho education.

After the administration of psycho education, none of the caregivers are having inadequate knowledge, 15% of them are having moderate and 85%of them are having adequate knowledge.



4.11The above figure illustrate care givers post test knowledge on adequate 85.00% &moderate 15.1%

Objective 4: To assess the effectiveness of the psycho education intervention..

Table 6: COMPARISON OF DOMAINWISE PRETEST AND POSTTEST KNOWLEDGE

	Pre-test		Post-test		Mean Difference	Student paired t-test
	No. of parents	%	No. of parents	%		
General information	13.2	2.38	24.1	1.31	10.9	t=10.31 P=0.001***Significant
Personal hygiene	20.4	2.68	28.45	1.41	8.05	t=9.79 P=0.001***Significant
Eating habit	6.1	1.23	9.85	.80	3.75	t=12.13 P=0.001***Significant
Maintaining environment to the client	7.2	2.38	11.55	1.21	4.35	t=12.49 P=0.001***Significant
Drug follow-up and	8.1	1.65	13.45	.93	5.35	t=12.49

home care						P=0.001***Significant

Fig 11

* Significant at P≤0.05 ** highly significant at P≤0.01 *** very high significant at P≤0.001

Table no.6 compares the Pre-test&Post-test disability of parents.

General information- Before psycho education, caregivers scored 13.2 and after psycho education, they are able to score 24.1 score. Therefore, the difference is 10.9. This difference is large and statistically significant,

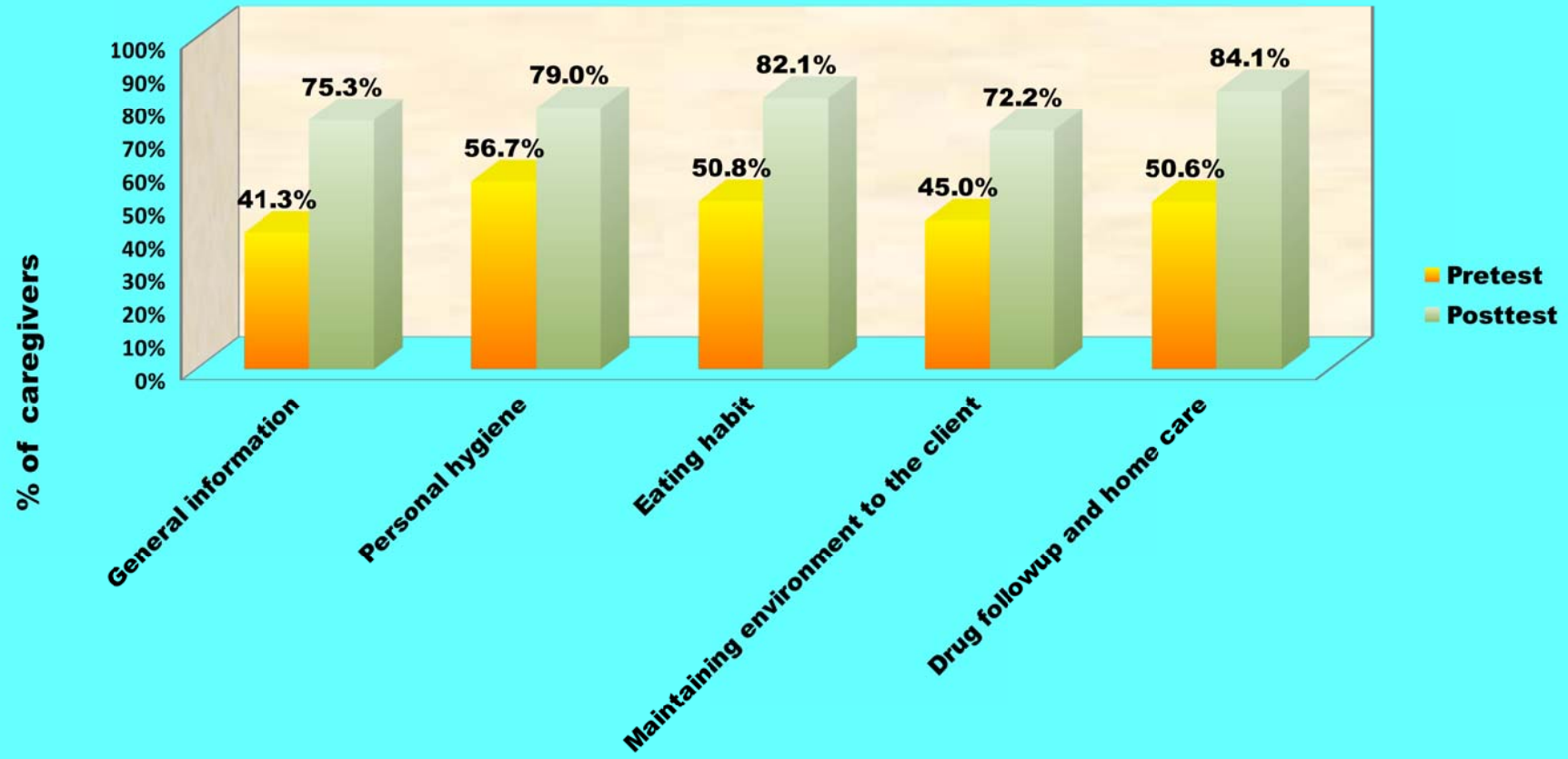
Personal hygiene- Before psycho education, caregiversscored 20.4 and after psycho education, they are able to score 28.45 score. Therefore, the difference is 8.05. This difference is large and statistically significant

Eating habit- Beforepsycho education, caregivers scored 6.1 and after psycho education, they are able to score 9.85 score. Therefore, the difference is 3.75. This difference is large and statistically significant,

Maintaining environment to the client- Beforepsycho education, caregiversscored 7.20 and after psycho education, they are able to score 11.55 score. So the difference is 4.35 this difference is large and statistically significant,

Drug follow-up and home care- Beforepsycho education, caregivers scored 8.10 and after psycho education, they are able to score 13.45 score. Therefore, the difference is 5.35. This difference is large and statistically significant, Statistical significance was calculated using student paired t-test.

EACH DOMAINWISE PRETEST AND POSTTEST PERCENTAGE OF KNOWLEDGE SCORE



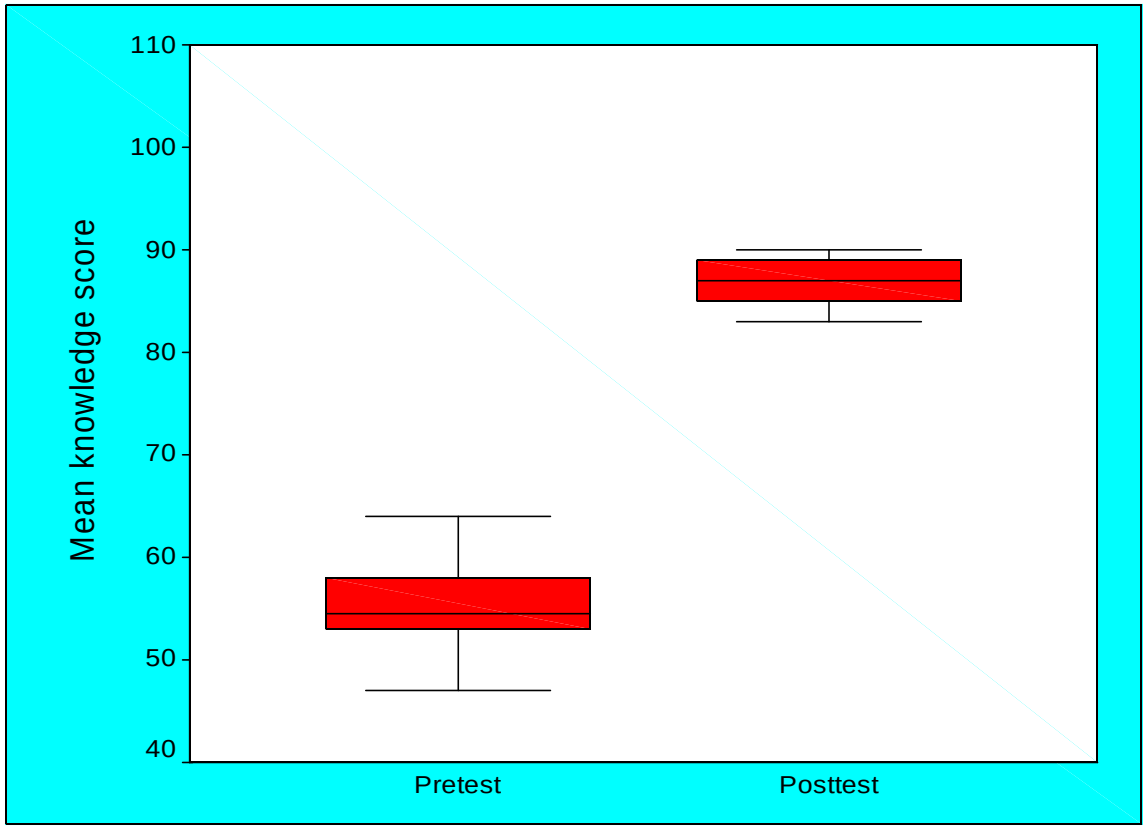
4.12The above figure illustrate care givers having knowledge on each domain wise pre and post test scores

Table 7: COMPARISON OF OVERALLKNOWLEDGE SCORE

	No. of caregivers	Mean ± SD	Mean difference	Student's paired t-test
Pre-test	60	55.00±4.46	32.40	t=45.40 P=0.001*** significant
Post-test	60	87.40±3.30		

* Significant at P≤0.05 ** highly significant at P≤0.01 *** very high significant at P≤0.001

(fig 12) Table no 7 compares pretest and posttest knowledge score. Considering overall, in pretest, caregivers scored 55.0 and after psycho education, they are able to score 87.40 score. So the difference is 32.4. The difference between pretest and posttest knowledge score is large and it is statistically significant. Differences between pretest and posttest knowledge was analysed using paired t-test.



	Pre-test		Post-test		Chi square test
	No. of caregivers	%	No. of caregivers	%	
Inadequate	24	40.0%	0	0.0%	$\chi 2=26.62$
Moderate	32	53.3%	9	15.0 %	P=0.001***
Adequate	4	6.7%	51	85.0 %	Significant
Total	60	100%	60	100%	

Fig13

* Significant at P≤0.05 ** highly significant at P≤0.01 *** very high significant at P≤0.001

Table no.8 compares thepre-test and post-test level of knowledge of caregivers on dementia a before and after administration of psycho education module.

Before psycho education, 40.0% of the caregivers are having inadequate knowledge, 53.3% of them are having moderate knowledge and 6.7% of them are having adequate knowledge.

. After the administration of psycho education,none of the caregivers are having inadequate knowledge, 15%none of them are having moderate and 85%of them are having adequate knowledge.Chi-square test was used to test thestatistical significance.

Knowledge on	% of Knowledge score		% of gain
	Pre-test	Post-test	
General information	41.3 %	75.3%	34.0 %
Personal hygiene	56.7 %	79.0%	22.3 %
Eating habit	50.8 %	82.1%	31.3 %
Maintaining environment to the client	45.0 %	72.2%	27.2 %
Drug follow-up and home care	50.6 %	84.1%	33.5 %
Total	49.1 %	78.0%	28.9 %

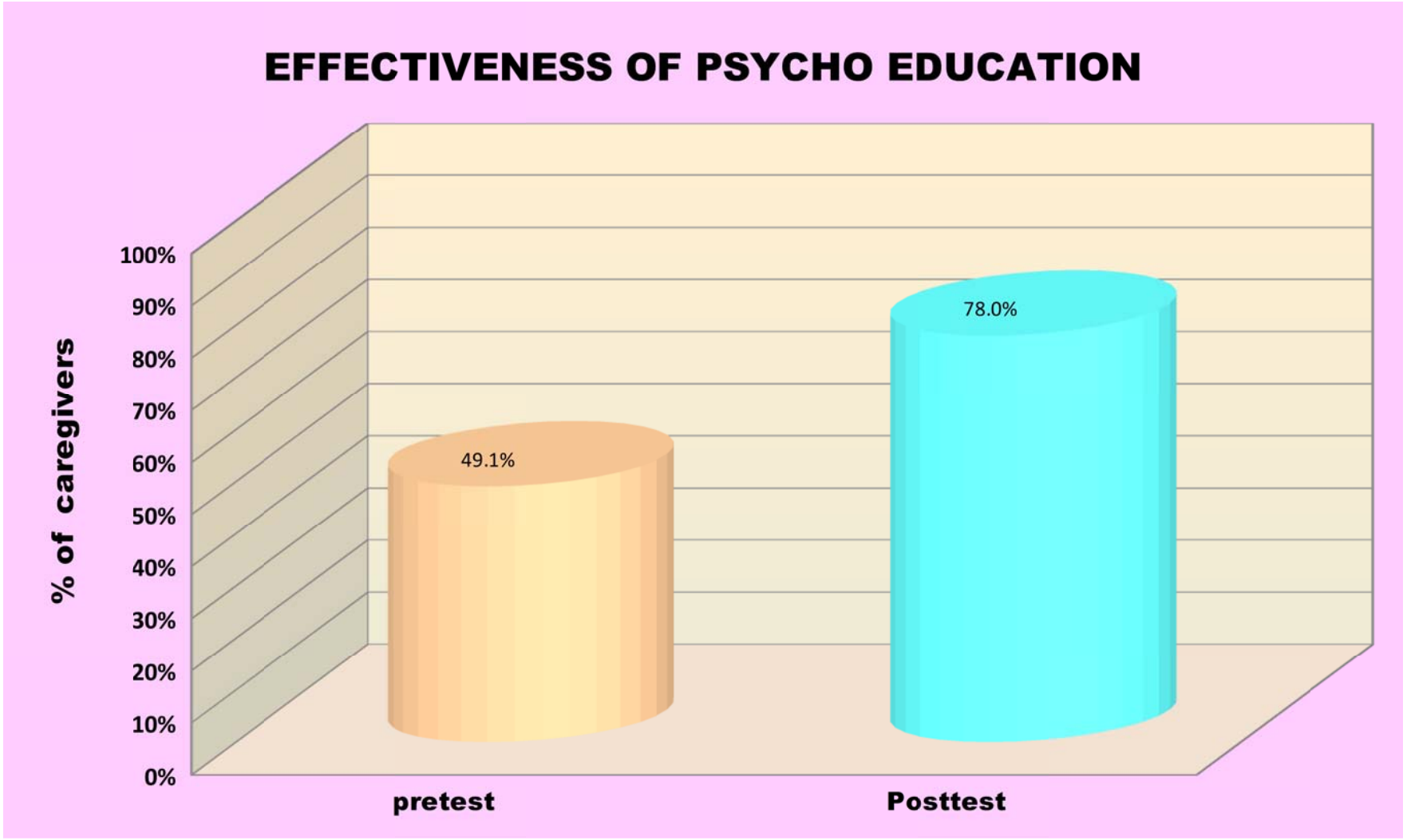
Fig 14, 15 Table 9 shows each

Table 10: EFFECTIVENSS OF PSYCHO EDUCATION

	Max score	Mean score	Mean gain difference in knowledge with 95% Confidence interval	Percentage gain difference in knowledge with 95% Confidence interval
Pre-test	112	55.00	32.60(30.97 – 33.83)	28.9 %(28.4% –39.1%)
Post-test	112	87.40		

Table no 10 shows the effectiveness of psycho education.

Parents are reduced 28.9% knowledge score after psycho education. This is the net benefit of this study. Effectiveness of study was analysed using proportion with 95% CI and mean difference with 95% CI.



4.14The above figure illustrate effectiveness of psycho education among care givers after post test78.45%

Objective 5: To associate the level of knowledge with selected demographic variables

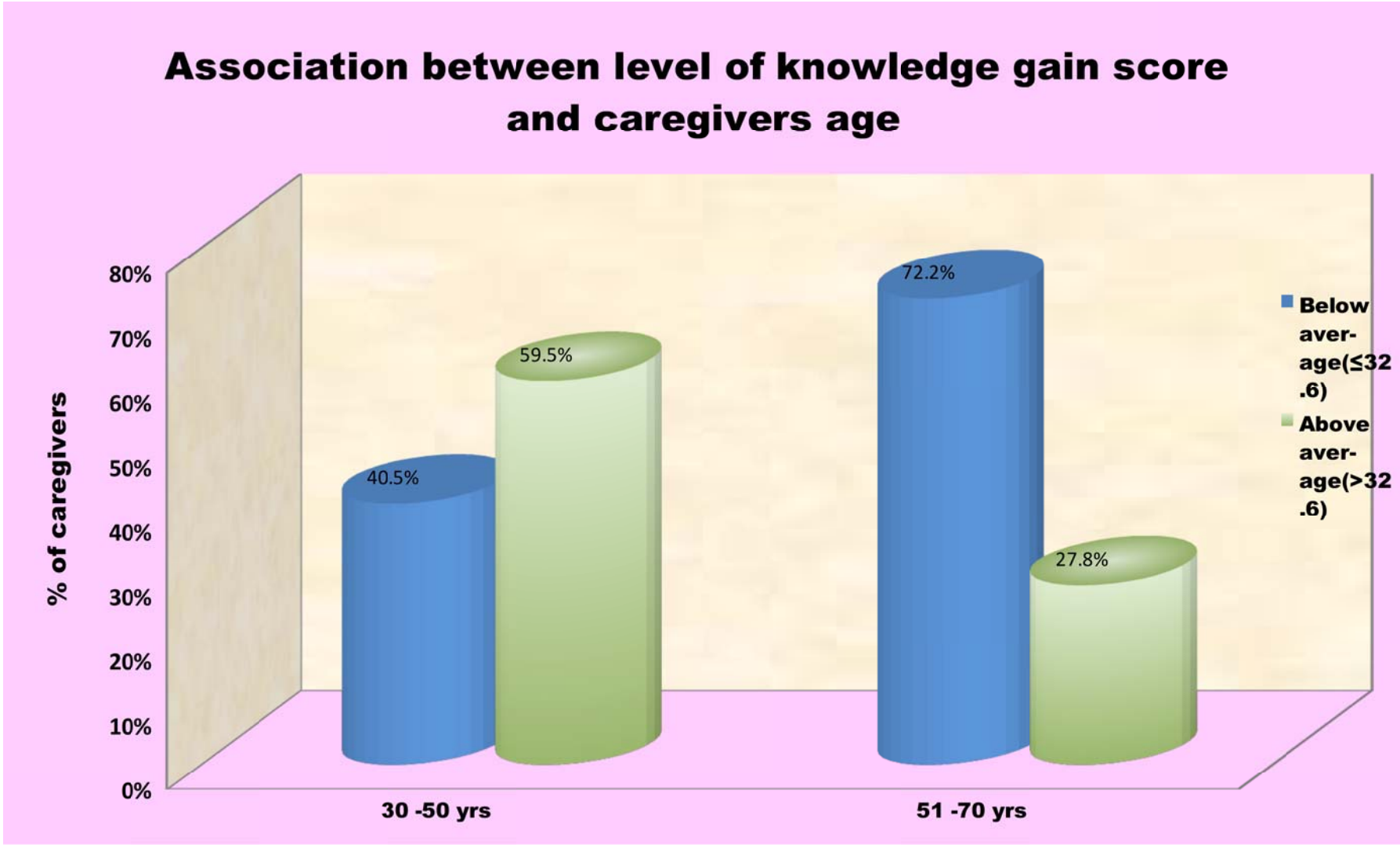
Table 11: ASSOCIATION BETWEEN LEVEL OF KNOWLEDGE GAIN AND DEMOGRAPHIC VARIABLES

Demographic variables		**Level of knowledge gain**				**Total**	**Chi square test**
		Below average (≤32.6)		**Above average (>32.6)**			
		n	**%**	**n**	**%**		
Age	30 -50 yrs	17	40.5%	25	59.5%	42	**χ2=5.07 p=0.02***
	51 -70 yrs	13	72.2%	5	27.8%	18	
Gender	Male	30	50.0%	30	50.0%	60	χ2=0.00 p=1.00
Education	No formal education	9	75.0%	3	25.0%	12	**χ2=6.00p=0.04***
	Primary school	18	50.0%	18	50.0%	36	
	High school	3	75.0%	9	25.0%	12	
Occupation	Private	12	40.0%	18	60.0%	30	χ2=2.40 p=0.12
	Business	18	60.0%	12	40.0%	30	
Religion	Hindu	30	62.5%	18	37.5%	48	χ2=1.66 p=0.40
	Christian	2	33.3%	4	66.7%	6	
	Muslim	2	33.3%	4	66.7%	6	
Marital status	Married	22	45.8%	26	54.2%	48	χ2=1.66 p=0.40
	Single	8	33.3%	4	66.7%	12	
Type of family	Joint family	2	16.7%	10	83.3%	12	**χ2=6.66p=0.01****
	Nuclear family	28	58.3%	20	41.7%	48	
Income	> Rs. 20000	3	50.0%	3	50.0%	6	χ2=0.75p=0.68
	Rs.5,000-10,000	23	47.9%	25	52.1%	48	
	<Rs.5000	4	66.7%	2	33.3%	6	
Source of information	Mass media	2	33.3%	4	66.7%	6	χ2=0.88 p=0.64
	Health personnel	10	55.6%	8	44.4%	18	
	Friends / Relative	18	50.0%	18	50.0%	36	

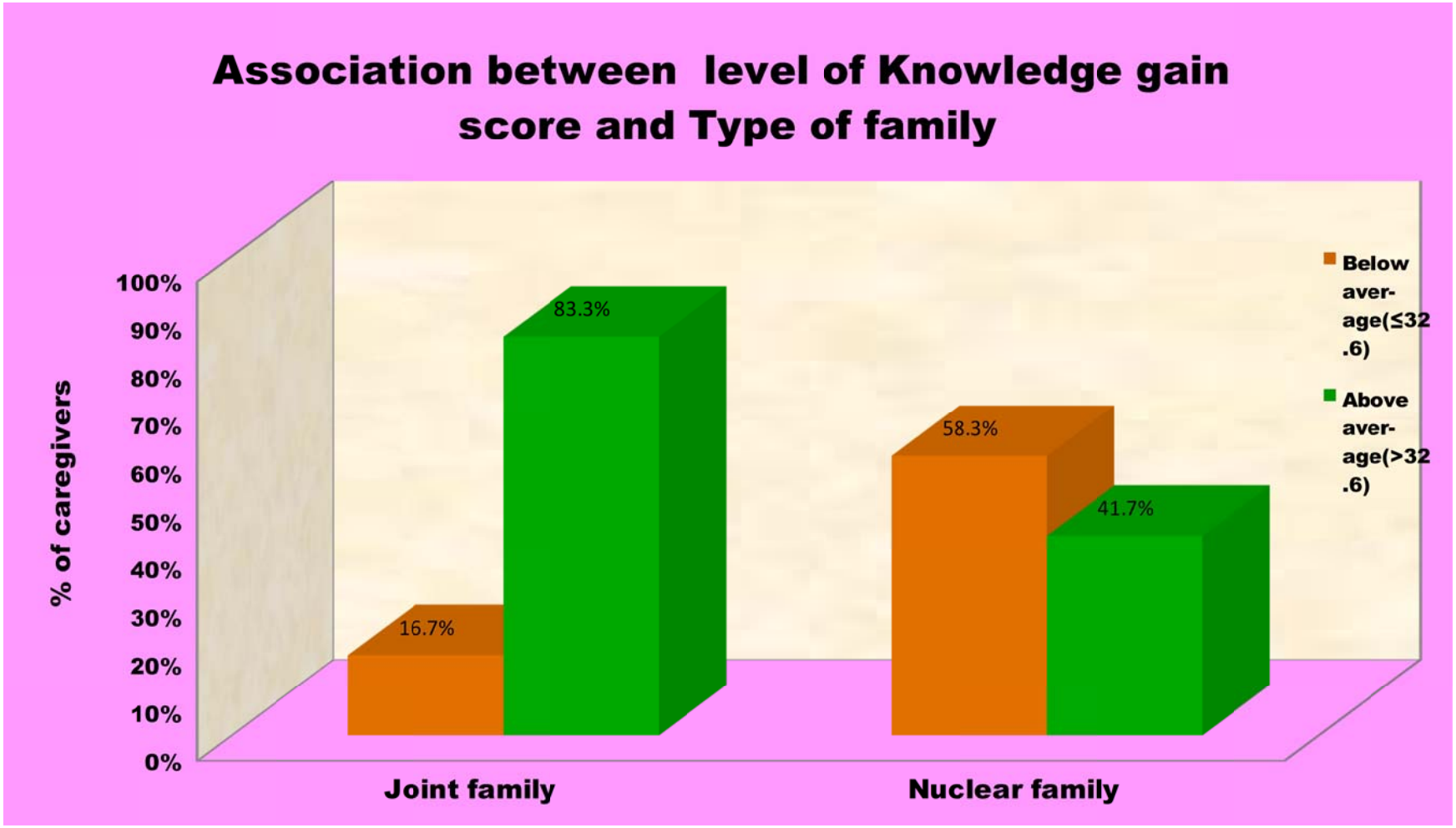
Relationship to patient	Spouse	15	50.0%	15	50.0%	30	$\chi 2=0.13$ p=0.93
	Daughter/daughter-in-law	8	44.4%	10	55.6%	18	
	Other relative	7	58.3%	5	41.7%	12	
Caregiver relationship with patient	Co-caregiver	30	50.0%	30	50.0%	60	$\chi 2=0.00$ p=1.00
Suffering from dementia	10-5years	22	64.7%	12	35.3%	34	**$\chi 2=6.78$ p=0.01****
	2 -5years	8	30.7%	18	69.3%	26	

Table 11 shows the association between level of knowledge gain and their demographic variables. Younger, **$\chi 2=5.07$ p=0.02*** more educated **$\chi 2=6.00$p=0.04***joint family **$\chi 2=6.66$p=0.01**** and less year caregivers **$\chi 2=6.78$ p=0.01****gained more knowledge. Statistical significance was calculated using chi square test

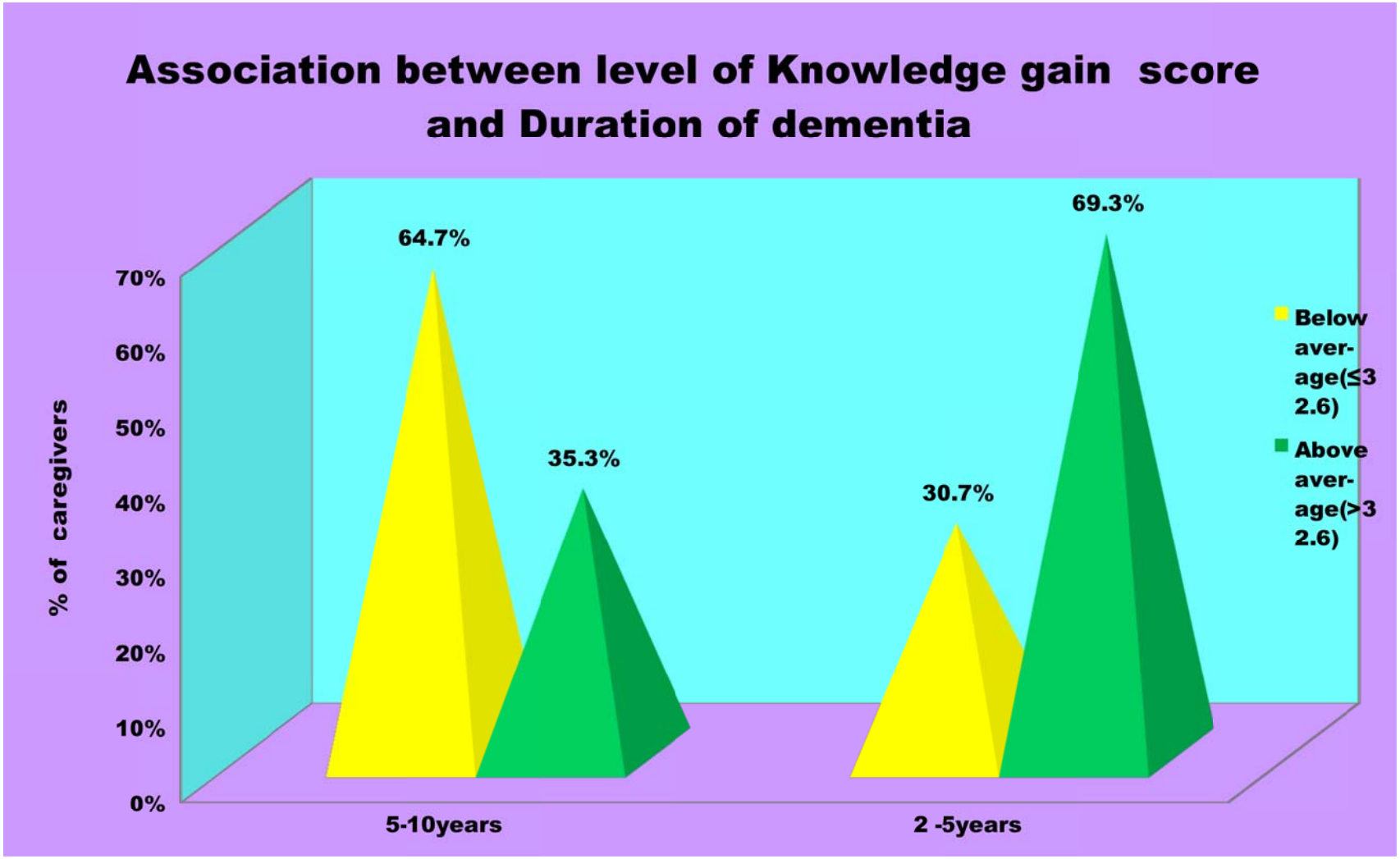
.


Association between level of knowledge gain score and caregivers age
% of caregivers
80%
70%
60%
50%
40%
30%
20%
10%
0%
40.5%
59.5%
72.2%
27.8%
30 -50 yrs
51 -70 yrs
Below aver-age(≤32.6)
Above aver-age(>32.6)

4.15The above figure illustrate association between knowledge score and care givers age $\chi 2=5.07$ p=0.02*



4.16The above figure illustrate association between knowledge score and care givers type of family $\chi 2=6.66 p=0.01^{**}$



4.17The above figure illustrate association between knowledge score and care givers duration $\chi 2=6.78$ p=0.0

CHAPTER -V

DISCUSSION

The analysis of collected data brought out many interesting and useful information by brochures, pamphlets that will be discussed below. These discussion helped investigation to be bring about important recommendations to prevent test anxiety among nursing students.

In this study investigator have assessed the effectiveness of psycho education module on knowledge regarding dementia among care givers of old age people residing in selected community area

Before psycho education, 40.0% of the caregivers are having inadequate knowledge, 53.3% of them are having moderate knowledge and 6.7% of them are having adequate knowledge.

. After the administration of psycho education, none of the caregivers were having inadequate knowledge, 15% of them are having moderate and 85%of them are having adequate knowledge. Finally each domain wise percentage of knowledge score. Overall, they gained 28.9% of knowledge.

The first objective of this study was to identify the socio demographic variables of the caregivers. In this study shows that age wise most of the care givers belongs to 30 -50 years,70.0%, the gender wise female care takers, 100%, education of care givers highest of them were primary school 60.0%, occupation of care givers equally of them were business and private was 50.0%, most of them were married 80%, type of family was majority of them belongs nuclear family 80.0%, income wise highest of them were middle income group 5000 -10000 80.0%, source of information gathered from highest by their spouses were 50.0%, co care giver were female care takers were 100%, and finally most of them suffering from dementia was 10- 5 years were 56.7%

This study is consistent with study conducted on Efficacy of a psychoeducational group with caregivers of patients with dementia (2013) by Raquel Luiza Santos; Maria Fernanda Barroso de Sousa; Cynthia Arcoverde The sample was primarily female, married, and had a high school or higher education. of the 171 participants, 126 (74%) identified themselves as White, 43 (25%) identified as African American, 1 caregiver identified as Hispanic, and 1 identified as other. Spouse caregivers represented 25% of the sample. Therefore, most caregivers were not spouses, with daughters and daughters- in-law constituting 59% of the sample; sons, sons-in-law, and grandsons 13% of the sample; and other family relationships (e.g., nephew) 3% of the sample. Caregivers were, on average, 61 years of age (range 23 to 92 years) and reported providing care for an average of 45 months (range 2 months to 16 years).

The second objective was to assess the knowledge regarding Dementia before and after psycho education intervention. In pre test maximum knowledge score in personal **hygiene** (56.7%) and minimum knowledge score in general information (41.3%). Overall they are having 49.1% of knowledge score, and 40.0% of the caregivers are having inadequate knowledge, 53.3% of them are having moderate knowledge and 6.7% of them are having adequate knowledge. In Post-test Maximum knowledge, score in personal hygiene (79.0%) and minimum knowledge score in general information (75.3%).eating habit (72.2%), Maintaining Environment to the client (72.2%) and Drug follow-up and home care (78.0%). After the administration of psycho education, none of the caregivers are having inadequate knowledge, 15% of them are having moderate and 85%of them are having adequate knowledge.

This study is similar with a survey-based study of knowledge of Alzheimer's disease among health care staff Wendy Smyth, Elaine Fielding, Elizabeth Beattie, Anne Gardner. Knowledge Test and consists of 30 true/false items [12]

with the resulting score being the number answered correctly [18]. Reliability of the ADKS measured by test-retest correlation = .81; internal consistency, as measured by the average inter-item correlation of α = .71 and content/predictive validity is adequate

This study is consistent with study on early dementia questionnaire (EDQ): A new screening instrument for early dementia in primary care practice conducted by Zurraini Arabi, Noor Azah Aziz, Aznida Firzah Abdul Aziz. The EDQ demonstrated a sensitivity of 79.2% with specificity of 52.7%. Positive predictive value (PPV) of EDQ was 23.5% with the negative predictive value (NPV) of 93.2%. The strongest predictor of possible early dementia was complaints of memory problems (OR 26.22; 95% CI 2.03â€“338.14) followed by complaints of concentration problems (OR 14.33; 95% CI 5.53â€“37.12), emotional problems (OR 4.75; 95% CI 1.64â€“13.81) and sleep disturbances (OR 3.14; 95% CI 1.15-8.56).

The third objective was to assess the effectiveness of the psycho education intervention. It reveals that General information, Before psycho education, caregivers scored 13.2 and after psycho education, they are able to score 24.1 score. Therefore, the difference is 10.9. This difference is large and statistically significant,
Personal hygiene, Before psycho education, caregivers scored 20.4 and after psycho education, they are able to score 28.45 score. Therefore, the difference is 8.05. This difference is large and statistically significant
Eating habit, Before psycho education, caregivers scored 6.1 and after psycho education, they are able to score 9.85 score. Therefore, the difference is 3.75. This difference is large and statistically significant,
Maintaining environment to the client, Before psycho education, caregivers scored 7.20 and after psycho education, they are able to score 11.55 score. So the difference is 4.35 this difference is large and statistically significant,

Drug follow-up and home care, Before psycho education, caregivers scored 8.10 and after psycho education, they are able to score 13.45 score. Therefore, the difference is 5.35. This difference is large and statistically significant,

This study is similar with a benefit-finding intervention for family caregivers of persons with Alzheimer disease: study protocol of a randomized controlled trial (2012) conducted by Sheung-Tak Cheng, **Rosanna WL Lau**, **Emily PM Mak**, **Natalie SS Ng.** The pre test outcomes are CG stress (subjective burden [31], role overload [33], and cortisol), perceived benefits (from open-ended questions), subjective health [34], psychological well-being [35], and depression [37]. The secondary outcomes are CG coping [39], and CR's BPSD [40] and functional impairment [42]. Same for group and individual interventions, all outcome measures, except cortisol, will be obtained at baseline (0 month; T1), post test outcome (2 months; T2), and 6 (T3), 12 (T4), 18 (T5) and 30 months (T6). Salivary cortisol, collected using the Salivette five times during the day (immediately after awakening, 30 minutes post-awakening, 45 minutes post-awakening, and at 11:00 and 21:00) for two consecutive days, will be obtained at T1-T4 only. This design will allow an assessment of the long-term effects of the interventions. The last assessment (T6)

The fourth objective was to associate the level of knowledge with selected demographic variables, it shows that the association between level of knowledge gain and their demographic variables. Younger **χ2=5.07 p=0.02***, more educated **χ2=6.00p=0.04***joint family **χ2=6.66p=0.01****and less year caregivers **χ2=6.78 p=0.01**** gained more knowledge.

This study is consistent with a study conducted on Clinical Characterization and the Caregiver Burden of Dementia in China conducted by Boxiong Tang, Eran Harary, Ricky Kurzman, Joaquı´n F. Mould-Quevedo among caregivers of patients previously diagnosed with dementia; decline in memory was the most

often cited reason for prompting a visit to the doctor (84.2%). The latency between the appearance of dementia symptoms and seeing a neurologist was greater than 3 years (28.2%), less than 6 months (21.0%), 1 to 2 years (20.0%), 6 to 12 months (16.6%), and 2 to 3 years (13.6%). In the majority of the cases (72%), the latency between the patient's first doctor visit and a confirmed diagnosis of dementia was less than 6 months.

Among caregivers of patients who were diagnosed with dementia at the time of screening, 31.4% responded that the latency between the appearance of dementia symptoms and seeing a neurologist was less than 6 months followed by more than 3 years (22.9%), 1 to 2 years (17.4%), 6 to 12 months (13.7%), and 2 to 3 years (12.6%). Only 15.3% of the caregivers indicated that the patient was completely aware of dementia symptoms at the first doctor visit

CHAPTER -VI

SUMMARY AND CONCLUSION

6.1 SUMMARY

Dementia is a typically progressive disease characterized by cognitive, functional, and/or behavioral deficits. The most well known and a common subtype of dementia is Alzheimer disease (AD); other subtypes include vascular dementia (VAD). Lewy body dementia and fronto temporal dementia. In 2010, it was estimated that 35.6 million people worldwide suffer from dementia. By 2030, approximately 65.7 million people will be living with dementia; and by 2050, the number is expected to increase to 115.4 million

Families provide the majority of care and support for the millions of adults in need of assistance. Likewise, the number of family caregivers is steadily increasing from an estimated 44 million in 2003 to 48.9 million in 2009. 1, 2 Many family caregivers have multiple, varied, and serious unmet financial, physical, emotional, and social needs. In order to continue providing care, family caregivers need assistance and support so that their physical and mental health needs are met rather than compromised (Judge et al., 2011).

The conceptual framework adopted for this study was modified Wiedenbach model. This model helped the investigator to approach the problem in a systematic manner. Review of related research and non-research literature healed the investigator how to prepare of the conceptual model, construct the tool and methodology of the study.

The research approach used for this study is Interventional approach. This study consists of pre test, psycho education module on knowledge regarding dementia and posttest method. The size of the sample study was 60 family caregivers of old age those who fulfilled the inclusion criteria residing in selected community area Choolai, Chennai-20.

The data collection procedure was conducted between 1.07.14 to 28.07.14 the investigator obtained collected history of 70 family care givers of old age who were identified with dementia disease condition; like poor in knowledge of dementia disease condition, personal hygiene, eating habits, maintaining environment for the client, follow up and home care. The obtained scores 86-55 were moderate and below 50 were poor on knowledge of dementia diseases condition. .

6.2 MAJOR FINDINGS OF THE STUDY

- Age wise most of the care givers belongs to 30 -50 years were 70.0%,
- Gender wise female care takers were 100%,
- Education of care givers highest of them were primary school 60.0%,
- Occupation of care givers equally of them were business and private was 50.0%,
- Most of them were married 80%,
- Type of family was majority of them belongs nuclear family 80.0%,
- Income wise highest of them were middle income group 5000 -10000 80.0%,
- Source of information gathered from highest by their spouses was 50.0%,
- Co care giver were female care takers 100%, and
- Finally suffering from dementia most of them were suffered for 10- 5 years was 56.7%
- After the administration of psycho education, none of the caregivers are having inadequate knowledge, 15% of them are having moderate and 85%of them are having adequate knowledge.
- **General information,** Before psycho education, caregivers scored 13.2 and after psycho education, they are able to score 24.1 score. Therefore, the difference is 10.9. This difference is large and statistically significant,
- **Personal hygiene, Before** psycho education, caregivers scored 20.4 and after psycho education, they are able to score 28.45 score. Therefore, the difference is 8.05. This difference is large and statistically significant
- **Eating habit,** Before psycho education, caregivers scored 6.1 and after psycho education, they are able to score 9.85 score. Therefore, the difference is 3.75. This difference is large and statistically significant,
- **Maintaining environment to the client,** Before psycho education, caregivers scored 7.20 and after psycho education, they are able to score

11.55 score. So the difference is 4.35 this difference is large and statistically significant,

- **Drug follow-up and home care,** Before psycho education, caregivers scored 8.10 and after psycho education, they are able to score 13.45 score. Therefore, the difference is 5.35. This difference is large and statistically significant, Statistical significance was calculated using student paired t-test.
- Psycho education, 40.0% of the caregivers are having inadequate knowledge, 53.3% of them are having moderate knowledge and 6.7% of them are having adequate knowledge.
- After the administration of psycho education, none of the caregivers are having inadequate knowledge, 15% of them are having moderate and 85%of them are having adequate knowledge.
- Each domain wise percentage of knowledge score. Overall, they gained 28.9% of knowledge

6.3 CONCLUSION

In this study 40.0% of the caregivers are having inadequate knowledge, 53.3% of them are having moderate knowledge and 6.7% of them are having adequate knowledge. After the administration of psycho education, none of the caregivers are having inadequate knowledge, 15% of them are having moderate and 85% of them are having adequate knowledge.

Considering overall, in pretest, caregivers scored 55.0 and after psycho education, they are able to score 87.40 score. So the difference is 32.4. The difference between pretest and posttest knowledge score is large and it is statistically significant.

By comparing the effectiveness of psycho education, 40.0% of the caregivers are having inadequate knowledge, 53.3% of them are having moderate knowledge and 6.7% of them are having adequate knowledge.

. After the administration of psycho education, none of the caregivers are having inadequate knowledge, 15% of them are having moderate and 85%of them were

having adequate knowledge. Caregivers were gained 28.9% knowledge score after psycho education. This is the net benefit of this study. Effectiveness of study was analysed using proportion with 95%

The association between level of knowledge gain of care givers of dementia clients were and their selective demographic variables. Younger **χ2=5.07 p=0.02***, more educated **χ2=6.00p=0.04***joint family **χ2=6.66p=0.01****and less year caregivers **χ2=6.78 p=0.01**** gained more knowledge.

6.4 IMPLICATIONS OF THE STUDY

The investigator has drawn the following implications from the study, which is important concern in the field of nursing research.

Nursing practice

Nurses will be trained in disease condition on dementia disease condition, aid clients living in the community would help the old age clients in identifying dementia, and understanding the causes of the particular dementia is related to senility, due to biochemical changes, cells degeneration cum metabolic effects and its related experience.

Nurses can help the home caretakers to follow certain daily properly drug intake, periodical review; check-ups reduce their recurrence and further problems among the clients.

Nurses must have continued nursing education programme especially on dementia, causes, home care management and other features in a detailed manner.

Nursing Administration

All the Nurses have direct home care during their community visit for the clients with dementia. As a community health nurse during their home visit they can

intervene for their health needs of elderly with dementia, she has to evaluate their problems in the home and in the society. If they are lack in need, she should counsel and guide the geriatrics people in the community.

The nursing administrator can conduct a mass program regarding home care of elderly people with dementia and to improve the level of daily activities, performance and coping in a home care of elderly with dementia.

Appropriate and operationally feasible programmes at the home level or in the district level and conducting a mass campaign such as psycho health education regarding home care of elderly with dementia through the Tamil Nadu state district mental health programme will be conducted. This measure will allow the community health nurse to pursue an optimal approach to the expanded and extended role of the job.

Nursing Education

The preparation of nurses for their role as a well qualified practitioners. In this regard to understanding of body –mind relationship and the importance of "Home care of elderly with dementia" will ensure the quality of community health services provided to the home care of elderly with dementia.

Home care of elderly with dementia given during the training period may improve the preparation of student nurses and reduce their care of elderly with dementia while they prepare for their board exams as a primary prevention measure.

Nursing Research

There is ample of scope for research in the field of home care of elderly with dementia and coping as seen by the result of the study thus further strengthening the nursing service.

❖ Studies can be done deeper into the area of home care of elderly with dementia and its reduction intervention. So that the suitable intervention can be developed.

❖ Research studies on home care of elderly with dementia and its promotion can help to identify the existing knowledge gap in the nursing profession.

❖ The study findings will motivate the other researchers to conduct studies with different variables on large scale.

❖ The evident of home care of elderly with dementia will be identified and suitable intervention strategies can be developed.

6.5 RECOMMENDATIONS

- Nurses can be appointed as community health nurses to promote the home care of elderly with dementia to be conducted in schools.
- Prevention and promotion of elderly with dementia disease and help the care takers.
- Complementary therapies like meditation, yoga can provide to the elderly in order to minimize their level of anxiety.
- Mass campaigns can be conducted to the home care takers at district level on home care of elderly with dementia.

6.6 SUGGESTIONS FOR FUTURE RESEARCH

In the light of the findings of the present study, the researcher puts forward the following recommendations for conducting future research.

- Similar study can be undertaken with large number of samples in different setting to strengthen the evidence based practice.
- Similar study can be conducted with intervention to find out the benefit of intervention in bringing down the level of stress.
- An experimental study can be undertaken with control group design.
- A comparative study can be done to find out a difference in the home care takers and in the hospital or in the old age home setup.

- Home care of elderly with dementia interventional programme can be conducted for nursing students with sufficient experts and source material for their best care in the hospital and in the community set up.

CONCEPTUAL FRAME WORK

All research studies have the frame work of back ground knowledge that provide the foundation for the study. The frame work serves to organize the study by placing it in the content of existing related knowledge as well as providing a context with in to interpret the result of the study.

Concept is defined as a complex mental formation of an object, promptly on or even experience. Theories and conceptual models are primary means providing a conceptual context for the study.

Conceptualization is a process of forming ideas, which are utilized and forms conceptual frame work for the development of research design. It helps to investigator to know what about data need to be collected and given direction to the entire research process.

The conceptual model selected for this study is based on “Widenbach’s helping arts of clinical nursing theory” adopted by Emestine Widenbach’s in 1964, which aims to assess the effectiveness of psycho education module on knowledge regarding dementia among care givers of old age people residing in selected community area.

The conceptualization of nursing practice according to the theory has three components which are as follows.

1. Identification of the patient need to help
2. Ministration of needed help
3. Validation of action taken to meet the needed help.

STEP –I- IDENTIFICATION

It refers to the determination of the clients need for help by the process of sample selection on the basis of inclusion criteria followed by assessing level of pain perception by using ”Pre assessment scale of knowledge of dementia” among care givers of old age people residing in selected community area.

STEP –II- MINISTRATION

It refers to the provision of needs help to fulfill the identified need.

It consist of three components

1. Central purpose
2. Prescription
3. Realities

CENTRAL PURPOSE:

It refers to the effective of psycho education module on improving knowledge regarding dementia among care givers of old age people residing in selected community area.

PRESCRIPTION:

A prescription refers to the activity which specified both nature of action and the thinking that will leads to fulfillment of nurse's central purpose. This include the psycho educational module on general information, personal hygiene, eating habits, maintaining environment to the client, drug follow up and home care, among the care givers of old age dementia people residing in selected community area.

REALITIES:

It indicates the factors that influence the nursing action this include 5 realities

1. **AGENT**
   The investigator- Community health psychiatric nurse.
2. **RECIPIENT**

   The care givers of old age dementia people residing in selected community area..

3. **GOAL**
   Improve the knowledge of dementia disease condition,
4. **MEAN**
   The psycho educational module on general information, personal hygiene, eating habits, maintaining environment to the client, drug follow up and home care, among the care givers of old age dementia people

5. **FRAMEWORK**
   It refers to the facilities in which nursing care is practical which indicate selected community area in Chennai.

STEP- III - VALIDATION:

Validation refers to the collection of evidence that shows the care givers need have been met that the knowledge, care of dementia and functional ability has been restored as a direct result of nurse's action. In this study validation includes improve the level of knowledge among care givers of old age dementia people residing in selected community area.

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Modified conceptual frame work of Widenbach's helping art of clinical nursing theory -1964

CENTRAL PURPOSE

Assess the effectiveness of psycho education module on knowledge regarding dementia among care givers of old age people residing in selected community area.

Step-I Identification

Collect the demographic details and Assess the knowledge level of dementia among care givers of old age people residing in selected community area

Step-II Ministration

Prescriptions

Step-III Validation

(AFTER POST TEST ASSESSMENT)

Care givers of old age people group

Increase on the knowledge

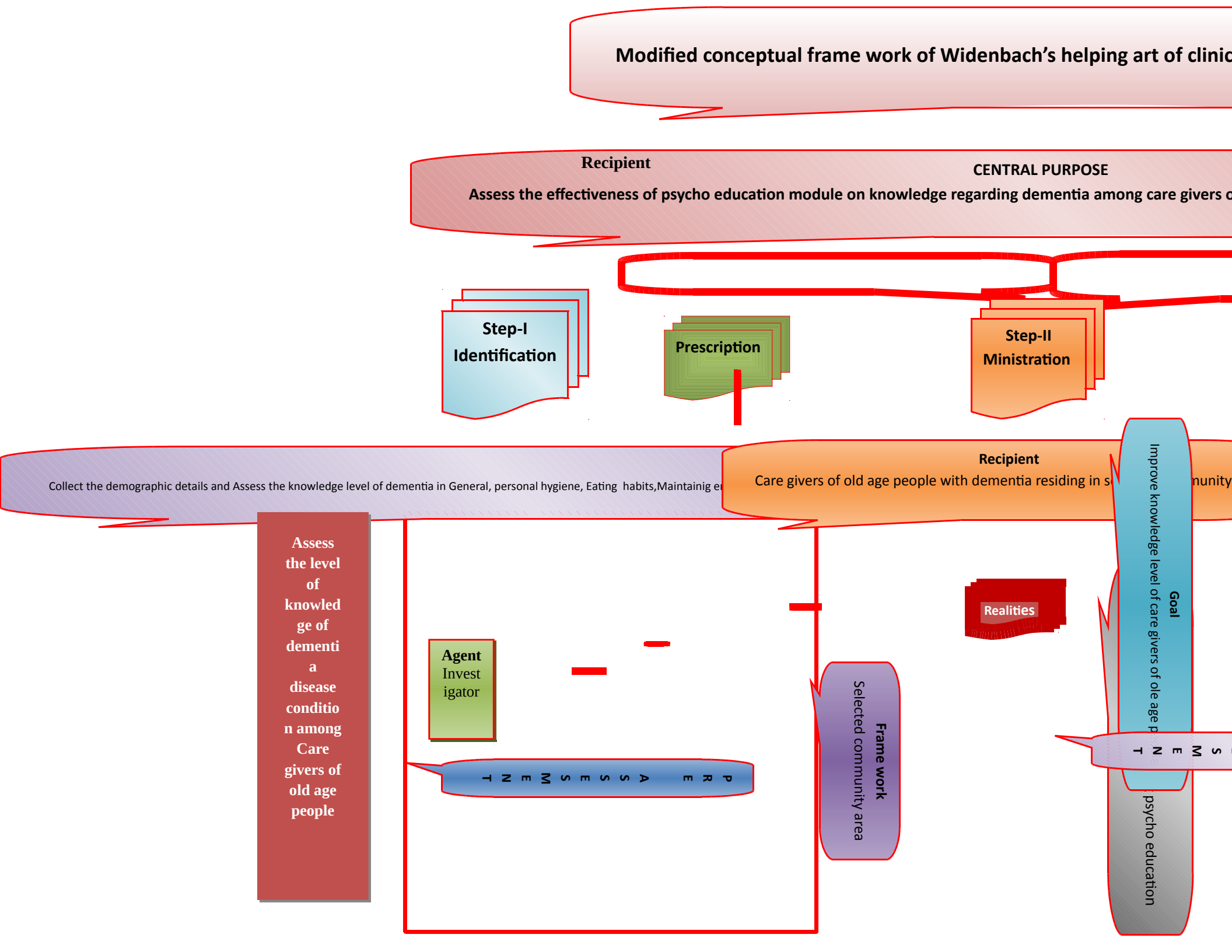
General information

Personal hygiene,

Eating habits,

Maintaining environment to the client,

Drug follow up and home care,


Modified conceptual frame work of Widenbach's helping art of clinic
Recipient
CENTRAL PURPOSE
Assess the effectiveness of psycho education module on knowledge regarding dementia among care givers o
Step-I
Identification
Prescription
Step-II
Ministration
Collect the demographic details and Assess the knowledge level of dementia in General, personal hygiene, Eating habits,Maintainig e
Recipient
Care givers of old age people with dementia residing in s
nunity
Assess the level of knowled ge of dementi a disease conditio n among Care givers of old age people
Agent
Invest igator
Realities
Goal
Improve knowledge level of care givers of ole age p
Frame work
Selected community area
psycho education

College of Nursing, Madras Medical College, Chennai-3

Questionnaire to assess the level of Knowledge on dementia among the care givers of old age people residing in selected community area.

SECTION –A DEMOGRAPHIC PROFILE

Name:

1. Age
   a) Less than 25 years
   b) 30-50 years
   c) 51-70 years
   d) 70-81 years
2. Gender
   a) Female
   b) Male
3. Education
   a) No formal education
   b) Primary school
   c) High school
   d) Higher secondary
   e) College
4. Occupation
   a) Government service
   b) Semi Government service
   c) Private
   d) Business
   e) Agriculture
5. Religion
   a) Hindu
   b) Christian
   c) Muslim
   d) Others
6. Marital status
   a) Married
   b) Single
   c) Divorced
   d) Widow /Widower
   e) Separated
7. Type of family
   a) Joint family
   b) Nuclear family
   c) Extended family
8. Income group
   a) Above 20000/=

b) 15000 – 10,000
c) 5,000-10,000
d) Below 5000

9. Source of information
   a) Mass media
   b) Health personnel
   c) Friends / Relative
   d) Other source

10. Relationship to patient
   a) Spouse
   b) Daughter/daughter-in-law
   c) Son/Son-in-law
   d) Other relative
   e) Friend

11. Care giver relationship to patient
   a) Primary caregiver
   b) Co-caregiver
   c) Secondary caregiver

12. Suffering from dementia
   a) 10-5years
   b) 2-5 years

13. Nature of attending outpatient department
   a) Regularly
   b) With break
   c) Occasionally

14. Intake of drugs
   a) Daily
   b) Alternative days
   c) Week end
   d) Occasionally

15. Extracurricular activities participation
   a) Daily in the evening
   b) Always playing
   c) Not at all participating
   d) Occasionally

16. Family history of dementia
   a) No
   b) Yes

c) Unknown

17. Performance of daily activity
    a) IADLs (range 9 to 21)
    b) PADLs (range 7 to 10)
    c) Total ADLs (range 16 to 31)

SECTION –B - KNOWLEDGE QUESTIONNAIRE

PART A- GENERAL INFORMATION:

1. Dementia is a memory loss condition
    1. Yes
    2. No
    3. Not sure
    4. Don't know
2. One of the commonest symptom of brain disorder is head ache
    1. Yes
    2. No
    3. Not sure
    4. Don't know
3. A majority of symptoms is Loss of memory and difficulty thinking
    1. Yes
    2. No
    3. Not sure
    4. Don't know
4. Problems with language, Confusion and agitation are minor symptoms
    1. Yes
    2. No
    3. Not sure
    4. Don't know
5. The cause of dementia is by hereditary as chromosomal disorder
    1. Yes
    2. No
    3. Not sure `
    4. Don't know
6. The most common are types of dementia is: Vascular dementia
    1. Yes
    2. No
    3. Not sure
    4. Don't know
7. Dementia is impairment of intellectual functioning
    1. Yes

2. No
3. Not sure
4. Don’t know

8. Dementia is most commonly seen in above 75 years of age
    1. Yes
    2. No
    3. Not sure
    4. Don’t know

Part –B KNOWLEDGE REGARDING PERSONAL HYGIENE

9. The client toilet should be labelled with dark coloured words or pictures and brightly illuminated
    1. Yes
    2. No
    3. Not sure
    4. Don’t know
10. During bathing the clients, the care givers should assist to them
    1. Yes
    2. No
    3. Not sure
    4. Don’t know
11. Bathing with oil should be avoided
    1. Yes
    2. No
    3. Not sure
    4. Don’t know
12. The client oral care should be maintained properly, regularly daily with follow up
    1. Yes
    2. No
    3. Not sure
    4. Don’t know
13. The client should use long handled and soft tooth brush and non irritating paste
    1. Yes
    2. No
    3. Not sure
    4. Don’t know
14. After the bath the skin of feet should be powdered and keep it clean and dry

1. Yes
2. No
3. Not sure
4. Don’t know

15. The foot of the client should be regularly massaged and nails trimmed in small size
    1. Yes
    2. No
    3. Not sure
    4. Don’t know

16. The client should be dressed clean dress with loosened fitting clothes
    1. Yes
    2. No
    3. Not sure
    4. Don’t know
17. The dementia clients should be shaved with electric shaver
    1. Yes
    2. No
    3. Not sure
    4. Don’t know

Part C- KNOWLEDGE REGARDING EATING HABITS

18. The dementia client should be served with small frequent small size cut pieces food
    1. Yes
    2. No
    3. Not sure
    4. Don’t know
19. For dementia client food table and environment will be in a clean and simple
    1. Yes
    2. No
    3. Not sure
    4. Don’t know
20. The serving food is not too hot nor too cold should be supplied in easy to hold plates and glasses
    1. Yes
    2. No
    3. Not sure
    4. Don’t know

PART D- KNOWLEDGE REGARDING MAINTAINING ENVIRONMENT TO THE CLIENT

21. Client environment must be in a protective manner(electrical, heat materials)
    1. Yes ☐
    2. No ☐
    3. Not sure ☐
    4. Don’t know ☐
22. Home with wide, few steps of stair case should be railed, non slippery floors etc
    1. Yes ☐
    2. No ☐
    3. Not sure ☐
    4. Don’t know ☐
23. Client frequent area should be oriented and keep the article of use near to them.
    1. Yes ☐
    2. No ☐
    3. Not sure ☐
    4. Don’t know ☐
24. Client should be familiar with surroundings and available articles in home
    1. Yes ☐
    2. No ☐
    3. Not sure ☐
    4. Don’t know ☐

PART E- KNOWLEDGE REGARDING DRUG FOLLOW UP AND HOME CARE

25. Dementia client should be periodically drug administered, follow up with psychiatrist
    1. Yes ☐
    2. No ☐
    3. Not sure ☐
    4. Don’t know ☐

26. Poor drug compliance, misconception on intake of drugs will worsen the disease condition
    1. Yes ☐
    2. No ☐
    3. Not sure ☐
    4. Don't know ☐
27. All family members combined co ordination will improve the client disease condition
    1. Yes ☐
    2. No ☐
    3. Not sure ☐
    4. Don't know ☐
28. Memory improving exercise and reorientation techniques improve client condition
    1. Yes ☐
    2. No ☐
    3. Not sure ☐
    4. Don't know ☐

Model -I

Outline for the Dementia Disease Knowledge Building Program

I. Week One: Understanding dementia Disease

A. Goals of the program

B. Types of dementia

C. Symptoms and stages

D. Risk factors

E. Treatment strategies

F. Research directions

II. Week Two: Communication Strategies That Work

A. What is communication?

B. Types of memory affected by Dementia

C. Common communication problems

D. General principles for maintaining communication

E. Compensating for memory problems

F. Compensating for verbal problems

G. Task breakdown

III. Week Three: Dealing With Changing Roles and Relationships

A. Awareness of the person with dementia

B. Adjusting perceptions and expectations

C. Shifting the balance of power

D. Practical issues in everyday life

E. Sharing the diagnosis with others

F. Getting others involved

IV. Week Four: Planning for the Future

A. Anticipating changes in the disease process

B. Considering a move

C. Participating in research

D. Using legal and financial tools

E. Tapping into community services

F. Understanding Medicare, Medicaid, and managed care

V. Week Five: Effective Ways of Coping and Caring

A. Educate yourself about the disease

B. Find a physician who understands the disease

C. Keep up supportive relationships

D. Find a confidante

E. Take time for leisure and exercise

F. Use community resources

G. Maintain a sense of humour

H. Explore religious beliefs and spiritual values

I. Set realistic goals

Model -II
Competency Areas and Objectives

A. Knowledge of Dementia Disorders

1. Identify the primary causes of dementia.
2. Differentiate between irreversible and reversible dementia.
3. Understand the definition and significance of delirium.
4. Describe how brain changes affect the way a person functions and behaves.
5. Discuss why it is important to individualize the care you provide to someone with dementia.

B. Person-Cantered Care

1. Discuss the key concepts of person-cantered care.
2. Describe how the background, culture, and experiences of a person with dementia affect care.

3. Describe how your background, culture, experiences, and attitudes affect care.

C. Care Interactions

1. Provide appropriate assistance with basic physical care tasks.

2. Identify and address the unique safety needs of persons with dementia.

3. Consider the person's abilities, needs, and preferences in order to maximize comfort, sense of well-being, and independence.

4. Obtain and apply knowledge of the individual's personal history; personal, religious, and spiritual preferences; and cultural and ethnic background.

5. Identify and validate the feelings, expressed verbally or nonverbally, of the person.

6. Demonstrate effective ways of listening to and communicating with someone who has dementia.

7. Discuss how various aspects of the environment may affect a person with dementia.

8. Understand why a person with dementia may be more vulnerable to abuse and neglect.

D. Enriching the Person's Life

1. Support and encourage individuals to maintain their customary activities, social connections, and community involvement.

2. Recognize the importance of persons engaging in activities that give meaning and purpose to them within the context of their cultural identity.

3. Recognize the role of pleasurable activities, including sexuality and intimacy, in a person's life.

E. Understanding Behaviours

1. Understand that behaviour is usually a form of communication and often represents an unmet need.

2. Recognize that a person's sense of appropriate behaviour may be influenced by cultural background. (For example, cultural background may influence behaviour related to gender roles, eye contact, and personal space).

3. Describe effective responses to behaviours that may be perceived as "challenging."

F. Interacting with Families

1. Respond to the family's unique relationships, experiences, cultural identity, and losses.

2. Use a non-judgmental approach with family members or when talking about the family with other staff.

3. Recognize the family as part of the care giving team.

G. Direct Care Worker Self-Care

1. Identify personal feelings, beliefs, or attitudes that may affect your caring relationships.

2. Identify helpful ways to prevent and cope with stress and burnout.

3. Identify the ways you cope with grief and loss.

4. Explain effective ways to talk with employers and co-workers about differences in philosophy or implementation of care practices, with a focus on what is best for the person with dementia.

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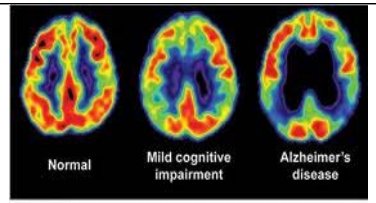
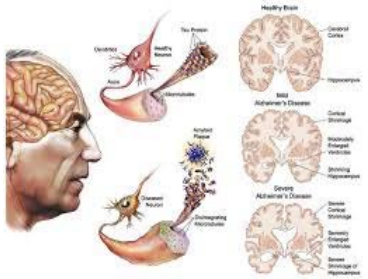


FDG-PET images show reduced glucose metabolism in temporal and parietal regions in Alzheimer's disease and mild cognitive impairment.

Courtesy of Drs. Suzanne Baker, William Jagust, and Susan Landau



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- நகங்கள் நீண்டு வளராமல் பார்த்து கொள்ளவேண்டும்
- சற்றே தளர்ந்த ஆடைகளை அணிய வேண்டும்
- மின்சாரத்தால் இயங்கும் பொருட்களை தவ ிர்க்கவேண்டும்

உணவு முறை :

- சிறு உணவு முறை ப ின்பற்ற வேண்டும்
- உணவு உண்ணும் இடம் தூய்மையாக இருக்க வேண்டும்
- உணவு மிதமான சூட்டில் பரிமார வேண்டும்

சுற்றுச்சூழல் பராமரிப்பு

- வழுக்காத தரை இருக்கவேண்டும்
- படிக்கட்டுகள் பெரியாதாக இருக்கவேண்டும்
- பக்கவாட்டில் கைப்பிடி இருக்கவேண்டும்
- அன்றாடம் பயன்படுத்தும் இடம் நன்கு தெரிந்து இருக்கவேண்டும்
- பயன்படுத்தும் பொருட்கள் அத்ற்குரிய் இடத்தில் இருக்கவேண்டும்

மருந்து சிகிச்சை

- மருந்து நேரம் தவறாமல் கொடுக்க வேண்டும்
- மருந்து மற்றும் மருத்துவ ச ிகிச்சை தொடர்ந்து கொடுக்க வேண்டும்
- மருந்துகளை குறைத்தோ அல்லது கூடவே தரக்கூடாது

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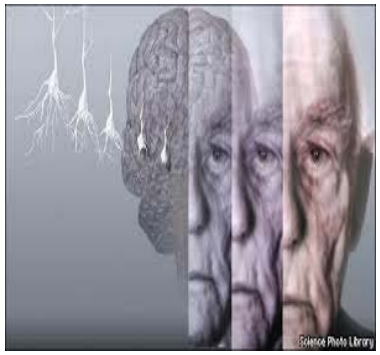

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INSTITUTIONAL ETHICS COMMITTEE
MADRAS MEDICAL COLLEGE, CHENNAI – 3.

EC Reg No.ECR/270/Inst.TN/2013
Telephone No : 044 25305301
Fax : 044 25363970

CERTIFICATE OF APPROVAL

To
Ms. R. Myvizhi,
M.Sc Nursing I Year
College of Nursing
Madras Medical College, Chennai – 3

Dear Ms. R. Myvizhi,

The institutional Ethics committee of Madras Medical College reviewed and discussed your application for approval of the proposal entitled **"A study to assess the effectiveness of psychoeducation module on knowledge regarding dementia among caregivers of old age people residing in selected community area."** No.27022014.

The following members of Ethics Committee were present in the meeting held on 24.02.2014 conducted at Madras Medical College, Chennai – 3.

1.	Dr.G.Sivakumar, MS FICS FAIS	--	Chairperson
2.	Dr.Kalai Selvi, MD Prof. of Pharmacology, MMC, Ch-3	--	Member Secretary
3.	Thiru. S. Govindasamy, BABL	--	Lawyer
4.	Tmt. Arnold Saulina, MA MSW	--	Social Scientist
5.	Prof. V. Padmavathi, MD I/C Director of Pathology, MMC, Ch-3	--	Member
6.	S. Ramesh	--	Lay Person

We approve the proposal to be conducted in its presented form

Sd/. Chairman & Other Members

The Institutional Ethics Committee expects to be informed about the progress of the study, any SAE occurring in the course of the study, any changes in the protocol and patient information / informed consent and asks to be provided a copy of the final report.

27/2/14

Member Secretary, Ethics Committee

VICE PRINCIPAL
MADRAS MEDICAL COLLEGE
CHENNAI-3.

From

The City Health Officer,
Public Health Department,
Corporation of Chennai,
Ripon Building,
Chennai - 600 003

To Ms. R. Myvizhi

The Nursing Students,
M.Sc., (Nursing) I Year,
College of Nursing,
Madras Medical College,
Chennai – 600 003

H.D.C.No.C2/1814/2014 Date : .03.2014

Sub: Corporation of Chennai - Public Health Department – Requisition for permission to conduct research study in Choolai, Chennai – Reg.

Ref: 1.Letters received from 11 Students studying M.Sc.,(Nursing) I Year, College of Nursing, Madras Medical College, Chennai-600 003. Dated: 07.03.2014.

2. Orders of the Deputy Commissioner, Dated. 18.03.2014

*****

As per the Orders of the Deputy Commissioner in the reference 2nd cited above 11 Nursing students studying M.Sc., (Nursing) I Year, College of Nursing, Madras Medical College, Chennai-600 003 are permitted to conduct Research Study on their topics.

The names of the students and their topics are mentioned below:

Sl. No.	Name of the Student	Topic
1	Ms. S. Sharmila	A study to assess the effectiveness of soya milk in reducing the malnutrition among malnourished children between 3-5 years of age in selected urban area at Choolai, Chennai.
2	Ms. M. Sakuntala	Assess the effectiveness of massage with ginger and orange essential oil among elderly women with knee pain residing at selected urban area of choolai, Chennai.
3	Ms. C. Lathapriya	Assess the effectiveness of Onion Juice in reducing Blood Glucose level among type II Diabetic adults residing at selected urban area Choolai, Chennai.
4	Ms. K. Kokilarani	A study to assess the effectiveness of amla juice with elemental iron versus elemental iron supplementation to increase the level of haemoglobin on anemic antenatal mother in selected urban area at Choolai, Chennai.
5	Ms. S. Thankaleelal	Assess the effectiveness of Beetroot Juice reducing hypertension among women residing at selected urban area Choolai, Chennai.
6	Ms. P. Revathi	A study to assess the effectiveness of foot reflexology in reducing the severity of menopausal symptoms among menopausal women in selected urban area Choolai, Chennai – 112.
7	Ms. J. Kayalvizhi	A study to assess the effectiveness of acupressure on dysmenorrhea among

8	Ms. S. Benazeer	A study to assess the effectiveness of cauliflower leaves on anaemia among women residing at selected community area Choolai, Chennai 112.
9	Ms. T. Jayasakthi	A study assess the effectiveness of cinnamon powder with Honey in reducing cholesterol among adults at selected urban area in Choolai, Chennai.
10	Ms. D. Lily Hannah Vinnarasi	A study to assess effectiveness of video assisted teaching programme on preventive measures regarding respiratory problem among cotton mill workers in selected urban industry at (Ramapuram) Chennai.
11	Ms. R. Myvizhi	Assess the effectiveness of psycho education module on knowledge regarding dementia among caregivers of old age people residing in selected community area Choolai, Chennai.

Deputy Commissioner (Health) has permitted the 11students with the conditions as detailed below:

1. All Publications should have reference to Corporation of Chennai, Public Health Department and the City Health Officer as Co-Author
2. Reports should be well informed to the Deputy Commissioner (Health) and City Health Officer
3. Negative Reporting about Corporation will be viewed seriously as per the relevant acts.

City Health Officer

Copy Submitted to:

Deputy Commissioner (Health)
City Health Officer
Copy to:

1. Individuals
2. The Zonal Officers, Zone I to XV
3. Zonal Health Officers, Zone I to XV

CERTIFICATE OF CONTENT VALIDITY

This is to certify that the tool constructed by Mrs.R.Myvizhi, M.Sc Nursing II year student, College of Nursing, Madras Medical College which is to be used in her study titled **"A study to assess the level of Knowledge on dementia among the care givers of old age people residing in selected community area."** has been validated by the undersigned. The suggestions and modifications given by me will be incorporated by the investigator in concern with their respective guide. Then she can proceed to do the research.

25.6.2014

SIGNATURE WITH SEAL

Vice Principal
Madha College of Nursing
Kunrathur, Chennai - 600 069.

NAME : MRS. GRACE SAMUEL

DESIGNATION : VICE PRINCIPAL

COLLEGE : MADHA COLLEGE OF NURSING

MADHA COLLEGE OF NURSING
25 JUN 2014
CHENNAI - 600 069

PLACE : CHENNAI

DATE : 25.06.2014

CERTIFICATE OF CONTENT VALIDITY

This is to certify that the tool constructed by Mrs.R.Myvizhi, M.Sc Nursing II year student, College of Nursing, Madras Medical College which is to be used in her study titled **"A study to assess the level of Knowledge on dementia among the care givers of old age people residing in selected community area."** has been validated by the undersigned. The suggestions and modifications given by me will be incorporated by the investigator in concern with their respective guide. Then she can proceed to do the research.

SIGNATURE WITH SEAL

NAME : DR.T. RANGANATHAN MD, DPM,

DESIGNATION : ASSISTANT PROF. OF PSYCHIATRY

COLLEGE :

DR. T. RANGANATHAN, MD, DPM.
Assistant Professor of Psychiatry
Department of Psychiatry,
Rajiv Gandhi Govt. General Hospital,
Chennai - 600 003.

PLACE : CHENNAI.

DATE : 24/6/14.

CERTIFICATE OF CONTENT VALIDITY

This is to certify that the tool constructed by Mrs.R.Myvizhi, M.Sc Nursing II year student, College of Nursing, Madras Medical College which is to be used in her study titled **"A study to assess the level of Knowledge on dementia among the care givers of old age people residing in selected community area."** has been validated by the undersigned. The suggestions and modifications given by me will be incorporated by the investigator in concern with their respective guide. Then she can proceed to do the research.

25/6/14

SIGNATURE WITH SEAL

NAME : Mrs. ANURADHA. C

DESIGNATION : Associate Professor

COLLEGE : Apollo college of nursing, Chennai - 95

PLACE : Chennai - 95

DATE : 25/6/14

Apollo College of Nursing
Apollo College of Nursing
Chennai - 600 095

CERTIFICATE OF CONTENT VALIDITY

This is to certify that the tool constructed by Mrs.R.Myvizhi, M.Sc Nursing II year student, College of Nursing, Madras Medical College which is to be used in her study titled **"A study to assess the level of Knowledge on dementia among the care givers of old age people residing in selected community area."** has been validated by the undersigned. The suggestions and modifications given by me will be incorporated by the investigator in concern with their respective guide. Then she can proceed to do the research.

SIGNATURE WITH SEAL

NAME : DR. K. VIJAYAN, MA, DM & SP. B. Ed.

DESIGNATION : ASSIST, PROF, OF PSYCHOLOGY

COLLEGE : INSTITUTE OF MENTAL HEALTH

K. VIJAYAN, M.A.,DM & SP., B.Ed.,
ASSISTANT PROFESSOR OF PSYCHOLOGY CUM
CLINICAL PSYCHOLOGIST.
INSTITUTE OF MENTAL HEALTH
KILPAUK, CHENNAI.

PLACE : CHENNAI

DATE : 25. 06. 14

INFORMATION TO PARTICIPANTS

Title **:A study to assess the effectiveness of psycho education module on knowledge regarding dementia among care givers of old age people residing in selected community area.**

Name of the Participant:

Date :

Age/sex :

Investigator : **R.Myvizhi**

Name of the institution : **Selected Community, Chennai-03**

Enrollment No :

You are invited to take part in this study. The information in this document is meant to help you decide whether or not to take part. Please feel free to ask if you have any queries or concerns.

You are being asked to Cooperative in this study being conducted in Selected Community, Chennai-03

What is the Purpose of the Research (explain briefly)

This research is conducted to evaluate the effectiveness of psycho education on knowledge regarding dementia we have obtained permission from the Institutional Ethical Committee.

Study Procedures

This study will be conducted in selected community area at Choolai. The sample size is 100 which will be divided into small groups of five (20 groups). Pre test will be conducted by using the structured questionnaire and psycho education will be given. After seven days of psycho education post test will be conducted for each group using the same structured questionnaire

- 1st Group 1st day pre test - 7th day post test
- 2nd Group 2nd day pre test - 8th day post test
- 3rd Group 3rd day pre test - 9th day post test

  Up to
- 20th Group 20th day pre test - 26th day post test

Possible benefits to other people

The result of the research may provide benefits to the care givers of dementia in terms of advancement of knowledge of dementia and also empathetic care to dementia people by care givers.

Confidentiality of the information obtained from you

You have the right to confidentiality regarding the privacy of your personal details. The information from this study, if published in scientific journals or presented at scientific meetings, will not reveal your identity.

How will your decision not to participate in the study affect you?

Your decisions not to participate in this research study will not affect your activity of daily living, medical care or your relationship with investigator or the institution.

Can you decide to stop participating in the study once you start?

The participation in this research is purely voluntary and you have the right to withdraw from this study at any time during course of the study without giving any reasons.

Your Privacy in the research will be maintained throughout study. In the event of any publications or presentation resulting from the research, no personally identifiable information will be shared.

Signature of investigator

signature of participants

Date

Date

ஆராய்ச்சி தகவல் தாள்

ஆராய்ச்சி தலைப்பு	:	**மூளை மறதி நோயால் பாதிகபட்டவர்களை கவனித்துகொள்பவர்களுக்கு இடையே இந் நோய் குறித்த அறிவு சர்ந்த படிப்பினையை மனந்ல கல்வி மூலம் வழங்கிய பின் ஏற்படும் விளைவுகள் குறிதத ஆய்வு**
ஆய்வாளர் பெயர்	:	இரா.மைவிழி
பங்கேற்பாளர் பெயர்	:	
தேதி	:	
வயது /பால்	:	
இடம்	:	சூளை , சென்னை

- ஆய்வாளர் மேற்கொள்ளும் ஆராய்ச்சியில்பங்கேற்க யாருடைய கட்டாயமுமின்றி முழுமனதுடனும் சம்மதிக்கலாம். இதில் பங்கேற்பதன் நோக்கம். இந்த ஆராய்ச்சியில் தகவல்களை தெரிந்து கொள்வதற்காகவும், அதனை பயன்படுத்துவதற்காக மட்டும் தான்.
- இந்த ஆராய்ச்சியின் நோக்கம், மனநல கல்வி மூலம் மூளை மறதி நோயால் பாதிக் கப்பட்டவர்களை கவனித்துகொள்பவர்களுக்கு மூளை மறதி நோய் பற்றிய அறிவுத்திறனை கற்றுத்தருவது,

ஆராய்ச்சி மேற்க்கொள்ளும் முறை

- இந்த ஆராய்ச்சியில், மூளை மறதி நோயால் பாதிக்கப்பட்டவர்களை கவனித்துகொள்பவர்களுக்கு ஆய்வாளர் தயார் செய்த படிப்பினை மூலம் மூளை மறதி நோய் குறித்த நோய்குறி காரண்ம், அறிகுறிகள், நோய் சோதனைகள்,மருத்துவ சிகிச்சை, பின் சிகிச்சை தொகுப்பு பற்றி கற்று தருவதற்கு முன்பு மற்றும் பின்பு அவருடைய அறிவுதிறன் அறியப்படும்.

இதனால் ஆய்வாளருக்கான பயன்

- **இந்த ஆய்விற்க்குபின் ஆய்வாளர் மூளை மறதி நோயால் பாதிகபட்டவர்களை கவ்னித்து கொள்பவர்களுக்கு, வீட்டில் நன்கு கவனித்து கொள்ளலாம் நோய்குறித்து** தொகுப்பு பற்றி கற்றுதந்ததன் தாக்கத்தினை அறியலாம்.

இதனால்பங்கேற்பாளருக்கான பயன்

- இந்த ஆய்வு மூளை மறதி நோயால் பாதிகபட்டவர்களை கவனித்து கொள்பவர்களுக்கு, வீட்டில் நன்கு கவனித்து கொள்ளலாம் நோய் குறித்த பின்விளைவுகளை தவிர்ப்பதற்க்கான அறிவு திறனை மேம்படுத்துகிறது.

INFORMED CONSENT

Investigator : R.Myvizhi

Name of Participant :

Age/sex :

Date :

Name of the institution:. Selected community, Chennai.

Title : A study to assess the effectiveness of psycho education module on knowledge regarding dementia among care givers of old age people residing in selected community area.

Documentation of the informed consent: (legal representative can sign if the participant is minor or competent).

- I _____have read/it has been read for me, the information in this form. I was free to ask any questions and they have been answered. I am over 18 years of age and exercising my free power of choice, hereby give my consent to be included as a participant in the study.
- I have read and understood this consent form and the information provided to me.
- I have had the consent document explained in detail to me.
- I have been explained about the nature of my study.
- My rights and responsibilities have been explained to me by the investigator.
- I agree to cooperate with the investigator
- I have not participated in any research study at any time.

- I am aware of the fact that I can opt out of the study at any time without having to give any reason
- I hereby give permission to the investigators to release the information obtained from me as a result of participation in this study to the regulatory authorities, government agencies and Institutional ethics committee. I understand that they are publicly presented.
- My identity will be kept confidential if my data are publicly presented.
- I am aware that I have any question during this study; I should contact the concerned investigator.

Signature of Investigator

Signature of Participants

Date

Date

"A STUDY TO ASSESS THE EFFECTIVENESS OF PSYCHO EDUCATION MODULE ON KNOWLEDGE REGARDING DEMENTIA AMONG CARE GIVERS OF OLD AGE PEOPLE RESIDING IN SELECTED COMMUNITY AREA"

M.Sc (NURSING) DEGREE EXAMINATION
BRANCH - V MENTAL HEALTH NURSING

COLLEGE OF NURSING
MADRAS MEDICAL COLLEGE, CHENNAI-600003

A dissertation submitted to
THE TAMIL NADU Dr.M.G.R MEDICAL UNIVERSITY
CHENNAI-600032

In partial fulfillment of the requirement for the degree of
MASTER OF SCIENCE IN NURSING
APRIL 2015

CERTIFICATE

This is to certify that this dissertation titled, **"A STUDY TO ASSESS THE EFFECTIVENESS OF PSYCHO EDUCATION MODULE ON KNOWLEDGE REGARDING DEMENTIA AMONG CARE GIVERS OF OLD AGE PEOPLE RESIDING IN SELECTED COMMUNITY AREA"** Is a bonafide work done by **Mrs.R.Myvizhi,** College of Nursing, Madras Medical College, Chennai-03 submitted to **The Tamil Nadu Dr.M.G.R Medical University, Chennai** in partial fulfillment of the university rules and regulations towards the award of the degree of **Master of Science in Nursing, Branch - V, Mental Health Nursing,** under our guidance and supervision during the academic period from 2013-2015.

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DISSERTATION
ON
"A STUDY TO ASSESS THE EFFECTIVENESS OF PSYCHO EDUCATION MODULE ON KNOWLEDGE REGARDING DEMENTIA AMONG CARE GIVERS OF OLD AGE PEOPLE RESIDING IN SELECTED COMMUNITY AREA"

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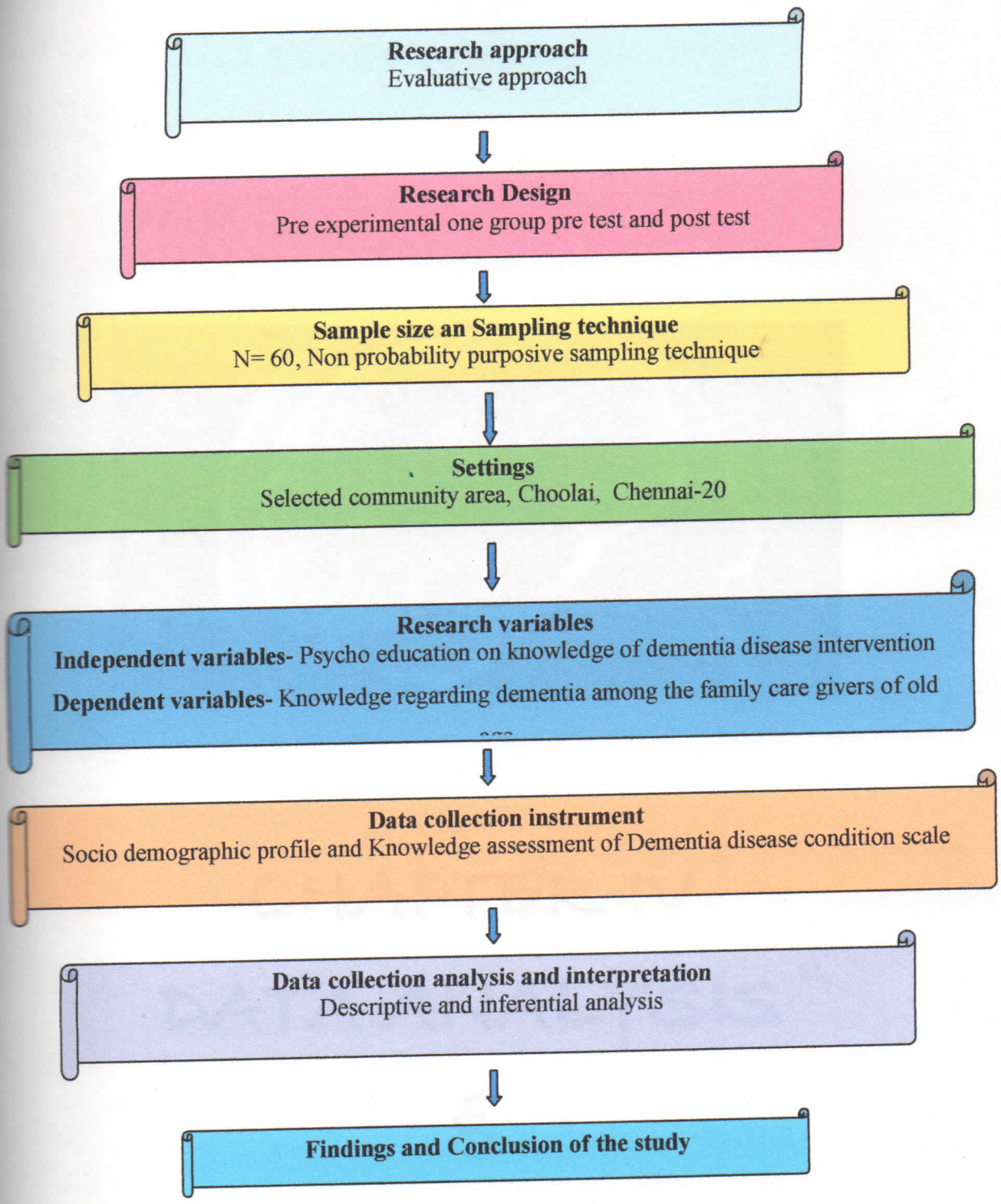

Fig: 2 SCHEMATIC REPRESENTATION OF THE STUDY

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